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ABSTRACT

This document contains a summary of and papers from an international conference convened by the World Health Organization Regional Office for Europe and the International Children's Centre to review training in family planning for physicians, nurses, midwives, and other health staff in countries of the European Region. The Introduction contains a brief summary of the conference proceedings. Chapter 1, "Present Position with Regard to the Teaching of Family Planning" includes: "The Teaching of Family Planning at Medical, Nursing and Midwifery Schools in Various Countries of the Region" (F. Puech and W. Haddad); "Complementary Study on the Teaching of Family Planning" (M. Pechevis); and a "Summary of Discussions." Chapter 2, "Introduction to Aspects of Family Planning," includes: "Problems in the Teaching of Family Planning and Sexuality" (M. Manciaux); "Strategy for Teaching Human Reproduction and Family Planning" (P. O. Hubinont); "The Social Status of Women and Family Planning in Developing Countries" (M. Ladjali and F. Oussedik); "Role of the Woman in Family Planning" (D. Nardini-Maillard); "Community Diagnosis" (T. Amat); "Psychosocial and Educational Aspects of Family Planning" (Ph. Lecorps); "Evaluation of Family Planning Activities" (E. Wollast); and "Pedagogical Support to Family Planning Programmes" (M. A. C. Dowling). Chapter 3 is "Activities of Study Groups: Some Reflections on Training in Family Planning" (K. Edstrom). Chapter 4 is a "Presentation and Discussion of a Draft Educational Handbook." Chapter 5 presents a "Summary of Plenary Meetings Grouped by Topic," and chapter 6 contains "Recommendations and Conclusions." A list of conference participants is appended. (NB)

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 160 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 33 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

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[a] Albania, Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, German Democratic Republic, Federal Republic of Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Morocco, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Spain, Sweden, Switzerland, Turkey, USSR, United Kingdom and Yugoslavia.

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Training in family planning for health personnel

Report on a WHO meeting

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The views expressed in this publication are those of the participants in the meeting and do not necessarily represent the decisions or the stated policy of the World Health Organization.

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Introduction

Training in family planning for physicians, nurses, midwives and other health staff appears to be very unsatisfactory in most countries of the European Region at present.

The WHO Regional Office for Europe and the International Children's Centre (ICC), which have together been holding courses in this field since 1973 with the financial assistance of the United Nations Fund for Population Activities (UNFPA), decided that an international conference should be convened to review the situation with regard to training in family planning and to determine what such training should be based on if it is to meet the true needs and requirements of the populations concerned.

The conference, arranged jointly by WHO and ICC, was held at the offices of the International Children's Centre in Paris and brought together participants from 21 countries (Algeria, Belgium, Bulgaria, Czechoslovakia, Egypt, France, the German Democratic Republic, Greece, Hungary, Italy, Madagascar, Morocco, Nigeria, the Netherlands, Poland, Portugal, Sweden, Tunisia, Turkey, the United Kingdom, and Yugoslavia), representatives of WHO headquarters and the WHO Regional Offices for Europe and the Eastern Mediterranean, the United Nations Fund for Population Activities, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the International Children's Centre and other international bodies (the International Federation of Gynaecology and Obstetrics, the International Confederation of Midwives and the International Planned Parenthood Federation).

Professor E. Aujaleu was elected Chairman and Mr P. Lecorps Rapporteur.

Dr Nafis Sadik, Assistant Executive Director and Chief, Programme Division, United Nations Fund for Population Activities, stressed the importance attached by the Fund to the training of personnel. In practice, this appeared to be one of the most effective ways of strengthening the institutional capacity of countries in the family planning sphere. Thus, out of the overall UNFPA budget devoted to family planning, one fifth had been allocated to training. The rise in the costs of programmes also required a new look at the concept of family planning and its public health components. Training programmes should therefore be reshaped in line with the

new directions taken by family planning policies. The latter formed part of the maternal and child health programme and social strategies in general; but before introducing programmes it was essential to arrive at a better understanding of the organization and way of life of different communities. Dr Sadik concluded by calling on participants to pool their experience in order to provide new solutions.

Dr A. Wojtczak, Director, Research, Planning and Human Resources at the WHO Regional Office for Europe conveyed to the participants the best wishes of Dr Leo A. Kaprio, WHO Regional Director for Europe. He recalled resolution WHA30.43 of May 1977 under which the Thirtieth World Health Assembly had defined WHO's goals for the twenty-first century. The Regional Office for Europe was playing a full part in the worldwide strategy to achieve "health for all by the year 2000". The "health for all" concept embodied a wide variety of concepts but presupposed the use of available resources to achieve a better life. Every society had to determine what was essential as a function of its manpower and economic resources. It would therefore be a question of, at one and the same time, promoting the adoption of lifestyles conducive to health, of reducing the incidence of preventable diseases and of providing acceptable care that was accessible to all; and in each of these domains family planning had a part to play. One could not help feeling pleased at the convening of this meeting, crowning as it did the long cooperation between WHO and ICC as well as other centres in Europe. The time had come to evaluate the programmes and to find new approaches and more effective means of action. After thanking Dr Sadik for the assistance from UNFPA, Dr Wojtczak expressed the hope that the discussions would be both enriching and stimulating.

Dr Angela Petros-Barvazian, Director, Division of Family Health at WHO headquarters, conveyed wishes of success to the conference from Dr Halfdan Mahler, Director-General of WHO. She expressed her recognition of the part played by the Regional Office for Europe and ICC in training in family planning and thanked Dr Sadik for the UNFPA contribution in the areas of staff training and the development of family planning programmes. During the past 20 years relations between WHO and developing countries with regard to family planning had undergone considerable change. Initially it had been necessary to answer the question of "why" family planning was necessary. It was now essential to answer the question of "how" to improve services. What was important was to provide arguments on the value of spacing pregnancies, on the structure of family development and on the recognition of the rights of couples, in such a way that the countries would provide their populations with services that left room for choice. It was now important to find the best possible way of organizing services at every level to meet the needs of the community.

The 1960s had been devoted to the study of what needed to be taught and the 1970s to the method of teaching; the 1980s should be used to deal with what was taught and how to teach it. It was imperative to find out how to prepare health workers without falling into the trap of overprofessionalization of simple problems, seeking a proper balance between training content

and training methods. She therefore called upon conference participants to display a spirit of innovation and suggest the direction that should be taken by training.

Mrs M.T. Pierre, Deputy Director for Motherhood, Childhood and Specific Health Actions at the French Ministry of Health, speaking on behalf of the Minister, welcomed the participants and assured them of the great interest aroused by this conference. In a brief historical summary she noted that it was not until 1967 that a law provided free access to contraceptive methods in her country, where there was no problem of excessive births since, despite restrictive laws, there had been effective fertility control practices since the eighteenth century. The fact was that in the modern day, women had new demands in relation to sexuality. In an existence where everything was programmed, and there was a right moment for every event, an effort had to be made to control fertility. In granting this right to women the State had supported the financial implications; it had set up reception centres, 600 family planning and education centres and 2000 information posts. The situation was not satisfactory, however, and the discussions during the years 1975–1979 showed that abortion still had an important part to play in France. Major questions remained unanswered.

There was no question today of dispensing with specific institutions or personnel such as marriage counsellors, but it was important to stress the training and role of all health personnel because they remained the best sources of information in this sphere. The move towards training was in line with the expectations of communities as well as the wishes of personnel who had a role to play that went beyond purely physical factors to concern itself with personal matters. All health personnel should be prepared to listen to those attending for consultations, to assist them both when they did not want to have children and when they did. She was convinced of the great interest represented by the conference; it should permit not only the knowledge and skills of health personnel to be improved but also their attitudes.

Professor M. Manciaux described the International Children's Centre, referring both to its history since being founded in 1949, and to its training, information, documentation and applied research activities.

1

Present position with regard to the teaching of family planning[a]

The teaching of family planning at medical, nursing and midwifery schools in various countries of the Region

F. Puech and W. Haddad

An intelligent view of problems connected with human reproduction, including the need for family planning, goes beyond the simple question of parental responsibility; it is also a question of responsibility in medical practice.

Health professionals should accept greater responsibility in matters connected with human reproduction, including sexual behaviour, since it has to do with an improvement in the quality of life.

For the exercise of that responsibility, health personnel must have been prepared to inform, prescribe, advise, supervise, guide, refer, interrupt, alter and pass judgements in respect of the contraceptive technique utilized.

As is shown in Fig. 1, there are many other categories of personnel concerned with planning, who should also be given suitable training: psychologists, psychiatrists, sexologists, family or marriage counsellors, social workers, lawyers, teachers at different levels, etc. With regard to the education of health personnel, however, it is to be regretted that although there is a high degree of excellence so far as the training of doctors, midwives and nurses in the health care of the individual is concerned, not all the desired importance has been attached to the question of sexuality and family planning. This at least is what can be established from a study of the present state of family planning education in medical, nursing and midwifery schools in seven countries in Europe (between one and three universities were visited in each country, i.e. a total of 19 departments of gynaecology and obstetrics, and schools of midwifery and nursing).

The purpose of the study was not to pass judgement on whether or not the role and priority allocated to the three categories of personnel was well founded even if it is obvious that a proper distribution of labour is bound

[a] This chapter summarizes the results of a study carried out in 1978 by the Regional Office for Europe and an additional study in 1981 of countries not included in the initial survey.

Fig. 1 Categories of personnel concerned with family planning

to increase the effectiveness of services provided to the community. It was rather to establish whether training, both theoretical and practical, was suited to the work assigned to the various types of personnel.

The study related to:

(*a*) *theoretical training*

- number of teaching hours provided;
- priority given to various aspects of family planning: medical and technical questions, marital psychology, sexology, sociology;
- distribution of this teaching in the various years of study;
- teaching methods used: traditional (lecture system) or active (discussion groups, case studies, etc.);
- type of teaching (whether or not multidisciplinary).

(*b*) *practical training*

- — time allocated to practical training, and length of practice;
- — organization of places for practical work;
- — teaching staff, their technical knowledge of the psychology of education and sexology;
- — evaluation of the importance attached to such teaching by checking on the knowledge acquired;
- — continuous education, whether or not arranged by health services, with the participation of professional bodies, etc.;
- — role and place of general practitioners, midwives and nurses in family planning.

It should be stressed that it was a *selective study* in between one and three universities in each of the countries visited and that the conclusions apply only to those institutions seen, which may not necessarily be representative of all universities and schools in the various countries: France, Italy, the Netherlands, Poland, Sweden, the United Kingdom and Yugoslavia.

Teaching at medical schools

University teaching

The length of university courses is more or less the same in all the countries visited, between five and six years.

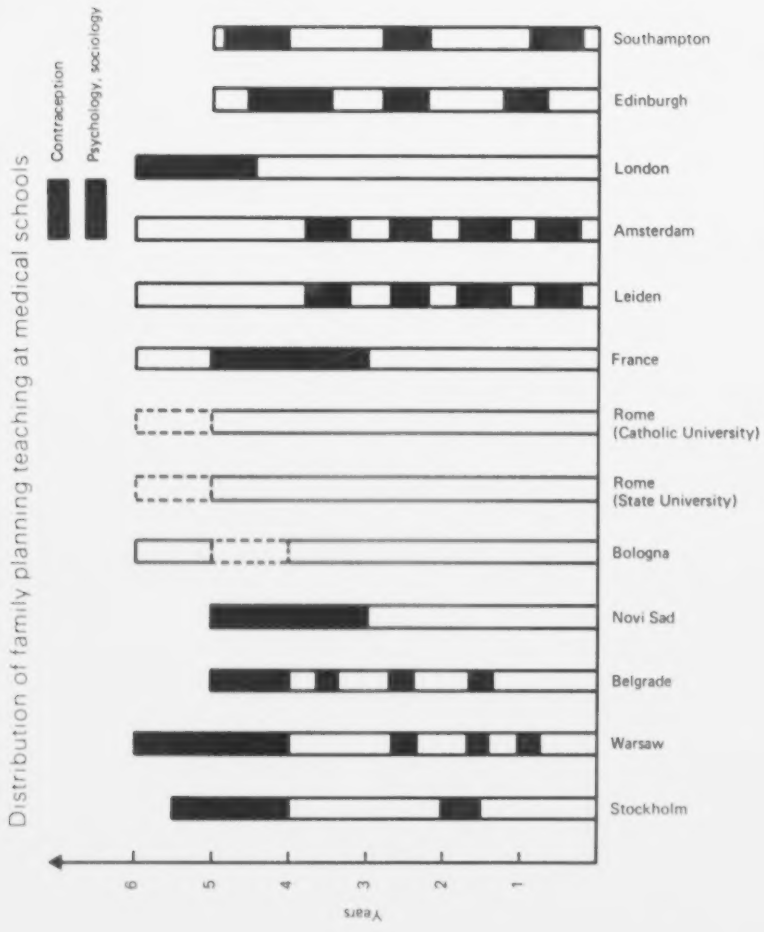
Fig. 2 shows the distribution of family planning teaching in various courses of medical training. The teaching of contraception is shown in black and that of psychology and sociology in grey, while the dotted segments indicate where teaching is optional.

It will be noted that the distribution of theoretical teaching during studies differs widely according to the countries visited:

- — out of the 13 universities visited in France, Italy, Poland, Sweden, United Kingdom and Yugoslavia, 9 provide family planning teaching mainly at the end of the course;
- — the two universities visited in the Netherlands (Leiden and Amsterdam) and two of the three universities visited in the United Kingdom (Edinburgh and Southampton) had training in gynaecology, obstetrics and family planning firmly attached to their studies in general.

It should be noted that in the three Italian universities visited, family planning matters come under a separate certificate or are included in the human reproduction certificate, but are always optional.

With regard to the number of hours allocated to the teaching of family planning, it should be noted that whereas the number of hours set aside for purely medical problems (contraception, abortion, sterility, etc.) is relatively clearly defined, albeit not the same everywhere, the lack of precision


Distribution of family planning teaching at medical schools
Contraception
Psychology, sociology
Southampton
Edinburgh
London
Amsterdam
Leiden
France
Rome
(Catholic University)
Rome
(State University)
Bologna
Novi Sad
Belgrade
Warsaw
Stockholm
6
5
4
3
2
1
Years

8

increases when it comes to calculating the number of course hours on sexuality, marital psychology and sociological aspects of family planning.

The results are shown in Table 1. The second column gives the number of hours in medical teaching, which range between 1 and 15. The third column shows the wide variation in the number of teaching hours set aside for the teaching of sexuality, ranging from 15 to nil (the term integrated teaching can be a synonym for imprecision). This is particularly true for the teaching of psychology and sociology, and the only place for which details have been obtained is the University of Leiden where two hours are set aside for family planning.

Practical teaching and training is given at the end of studies in all of the universities visited except the University of Southampton, which provides practicals from the first year onwards.

The last column gives the length of clinical work in gynaecology and obstetrics (GO) and family planning (FP). The family planning clinical stage is most often integrated with the gynaecology and obstetrics clinical phase. The use of crosses in this column is an attempt at qualitative appreciation of the importance given to family planning during the gynaecology and obstetrics clinicals.

In most of the countries visited all students undergo a clinical phase in the gynaecology and obstetrics department, except in France where a certain percentage attend voluntarily and in Italy where the clinicals are not obligatory (except at the Catholic University of Rome where all students have access to hospital departments).

Clinical practice in gynaecology and obstetrics departments is of varying length. It should also be noted that practical periods spent in obstetrics and gynaecology departments do not necessarily signify access to family planning consultations.

Although access to antenatal consultations is the rule, attendance at family planning consultations is not included in the syllabus for students in Bologna, or in Rome at the State University or the Catholic University, and it is almost non-existent at the University of Stockholm, where clinical practice in this sphere is set aside for student midwives.

It should be noted that post-confinement units in the maternity departments of the university hospital centres provide, where there is no access to family planning consultation centres, a particularly good opportunity for teaching contraception "around the post-partum bed", and one which does not always seem to be used as well as it might be.

The integration of all teaching in the clinical period spent on the gynaecology and obstetrics wards, as is the practice at University College Hospital, London, and soon to be the case at University College Hospital, Edinburgh, seems very promising but presupposes deep-rooted changes in the teaching of medicine.

In most of the traditional universities visited the teaching methods remain by and large based on the lecture approach. A perceptible movement towards active methods can be felt at certain universities, for example

Table 1. Family planning teaching at medical schools

Place	Medical teaching	Sexuality	Psychology and sociology	Family planning clinical work	
Stockholm	8 hours	4 hours	Integrated	GO[a]	approx. 4 weeks
				FP[b]	0
Warsaw	6 hours	Integrated	Integrated	GO	17 weeks
				FP	+++
Belgrade	>10 hours	Integrated	Integrated	GO	114 hours
				FP	+++
Novi Sad	12 hours	Integrated	Integrated	GO	
				FP	2 weeks
Bologna	25 hours optional	3 hours optional		GO	0
				FP	0
Rome (State University)	1-2 hours	0	Integrated	GO	0
				FP	0
Rome (Catholic University)	25 hours optional	0		GO	8 weeks
				FP	0
Tours	8 hours	1-3 hours	Integrated	GO	approx. 12 weeks
				FP	+
Leiden	15 hours	15 hours	2 hours	GO	10 weeks
				FP	+++
Amsterdam	15 hours	5 hours	Integrated	GO	16 weeks
				FO	+++
London	7 hours	8 hours	Integrated	GO	15 weeks
				FP	+++
Edinburgh	10 hours	Integrated	Integrated	GO	8 weeks
				FP	+
Southampton	7 hours	5 hours	Integrated	GO	10 weeks
				FP	+

[a] GO: gynaecology and obstetrics.

[b] FP: family planning, mostly integrated with the gynaecology and obstetrics clinicals. The number of crosses is an attempt at a qualitative assessment of the importance attached to family planning during the gynaecology and obstetrics clinicals.

Stockholm, Warsaw, Novi Sad and Southampton. For its part, the University of Leiden appears to have integrated active methods in its teaching of family planning particularly effectively.

Audiovisual aids are used at all the universities, but the best equipped is the University of Leiden where courses are recorded on video-cassettes and are permanently accessible to students who can also check the progress of their knowledge using a multiple choice test paper, thereby obtaining immediate verification.

Postgraduate education

Specialist training in gynaecology and obstetrics ranges from four to seven years. Training in family planning varies: extensive provision for it is made in every country except France, Italy and Sweden. In Sweden, it is the result of deliberate disinvolvement, family planning being the province of midwives.

Continuing education

Continuing education is provided in all countries visited. Several different approaches are possible:

— courses outside working hours (evening courses, weekends);

— discussion evenings, seminars;

— short courses (several days) on gynaecology and obstetrics wards.

Among the basic conditions for attendance at such continuing education courses (where they are not mandatory as in the Eastern European countries) the following must be noted:

— reimbursement of costs;

— relevance of the subjects studied;

— teaching of high quality (in terms both of teaching methods used and of practical content).

In the United Kingdom, two interesting approaches to continuing education in family planning are worth referring to:

— the first is training in family planning leading to the award of a diploma;

— the second is multidisciplinary weekend seminars on family planning.

These courses are subsidized by the Department of Health and Social Security and the World Health Organization.

They have been a great success and have now been extended to other centres in the country.

These three-day multidisciplinary courses, held several times a year, are intended for general practitioners, physicians working as family planning instructors, and specialists, but are also attended by medical students, teachers, social workers, nurses, midwives, lawyers, etc.

The teaching of family planning at nursing schools

Basic education

Courses of study leading to the award of a nursing diploma vary between two and four years in the different countries visited.

Theoretical training in family planning was particularly poor at all the nursing schools visited. Purely technical training lasted "a few hours", ranging from simple information sessions, as at Bologna, to seven hours of special training, as at the National Assistance School of Nurses in Paris.

Survey results are given in Table 2.

Table 2. Teaching of family planning at nursing schools

Place	Length of course	Family planning	Sexuality	Practical training	
Stockholm	2½ years	a few hours integrated		GO[a] FP[b]	4 weeks almost 0
Warsaw	2 years 5 yrs + 2	a few hours		GO FP	40 hours almost 0
Belgrade	4 yrs + 1	3-4 hours		GO FP	 almost 0
Novi Sad					
Bologna	3 years	information only	0	GO FP	3 months 0
Rome (State system)					
Rome (Catholic system)	3 years	3 years	0	0	
Paris	2½ years	7 hours	0	GO FP	2 weeks 1-2 classes
Leiden	3½ years	4 hours	2 hours	FP	0
Amsterdam	3½ years	integrated	6 hours	GO FP	3 months almost 0
London	3 years	2 hours		GO FP	12 weeks almost 0

[a] GO gynaecology and obstetrics

[b] FP family planning

Teaching of sexuality is practically non-existent in all countries apart from the Netherlands (two hours at Leiden and six hours at the Amsterdam School of Nursing).

Finally, no nursing school has arrangements for practicals at family planning centres; those given in departments of gynaecology and obstetrics vary in length between one week and three months.

Postbasic education and continuing training

In addition to basic education, additional training leading *inter alia* to the diploma of public health nurse, exists in courses lasting an extra 1–2 years.

Training in family planning is naturally given more weight than during basic education (four hours of theoretical teaching on average) but is still not enough.

Public health nurses, however, have an important role in family planning, particularly in rural areas, but their training, it has to be admitted, then depends on their personal interest in the matter. It should be noted that in the United Kingdom such "advanced" training, both for midwives and nurses, is remarkably well organized and incidentally reflects the understanding that public health nurses have demonstrated for many decades in the role they have to play in family planning.

Their role as adviser and assistant to the physician is incidentally in the process of being extended to more important responsibilities such as the prescription of contraceptives and insertion of intrauterine devices, through experiments that for the moment are on a pilot basis (London).

Teaching of family planning in schools of midwifery

Results of this study are summarized in Table 3.

Basic education

Studies range in duration from two to four years, with the nursing diploma being a prerequisite in most of the countries visited (except in France and the United Kingdom).

Theoretical training in family planning varies widely and generally corresponds to the level of responsibility in the matter allocated to the midwive.

The most comprehensive training is undoubtedly that provided in Sweden, with regard both to theoretical training and to practical field training and practicals at family planning centres. This is to be explained by the fact that it is the midwifery profession that is responsible for family planning problems as a whole.

In the Netherlands and Poland the programme, although less extensive particularly in practical terms, is nevertheless better than the average level of teaching in medical schools.

At the same time, teaching in human relations between the two sexes remains inadequate, in particular in France, Italy and the United Kingdom, and seemingly in Yugoslavia too.

Access to family planning consultations is thorough enough and effective enough to be of use in most of the countries visited.

Table 3. Teaching of family planning at midwifery schools

Place	Length of course	Medical education	Sexuality	Psychology, sociology, teaching methods	Family planning		Continuing education
Stockholm	2½ years 2 years of practicals	integrated >10 hours>	integrated	14 hours	PW[a] TC[b]	60 hours 6 weeks	4 weeks obligatory, every 10 years
Warsaw	2½ years 2 years of practicals	8 hours	5 hours	22 hours	PW TC	integrated 2 weeks	1 month obligatory, every 5 years
Belgrade	4 years	4 hours		2 hours	PW TC	8 hours approx. 2 weeks	5 days per annum
Bologna	2 years	4 hours	0		PW TC	≧0 ≧0	≧0
Rome (State system)	2 years	approx. 13 hours	approx. 8 hours		TC	2 weeks	
Rome (Catholic system)	2 years	approx. 5 hours	approx. 1 hour		PW TC	approx. 10 hours ≧0	once every 4 years non-obligatory
Paris	3 years	6 hours	≧0	>2 hours	PW TC	4 hours approx. 2 weeks	once a year 3 half days
Leiden	3 years	Integrated 10 hours	5 hours	55 hours	TC	6 weeks	
United Kingdom	2 years	2 hours	≧0		PW TC	40 hours 2 consultations	government-organized lectures

[a] PW: practical work.

[b] TC: inservice training courses.

It should be noted that in contrast to the medical schools, active teaching methods such as group discussions, sociodramas, etc. are widely used in most midwifery schools in the Netherlands, Poland and Sweden.

Advanced training

Generally speaking, whatever the country visited, the midwife instructors in charge of training have an excellent background in the psychology of education.

Continuing education

Two types of training should be contrasted, one being continuing education properly speaking and the other consisting of simple additional basic training to fill in the gaps in training programmes that are too superficial, and to help midwives acquire responsibilities in the family planning sphere.

Facilities exist for refresher training in Poland, Sweden and Yugoslavia, where it is obligatory, with an integral family planning component. Non-mandatory facilities also exist in France, Italy, the Netherlands and the United Kingdom.

Provision of additional training in family planning giving enough knowledge to permit responsibilities to be assumed is a major concern in the Netherlands, Sweden and the United Kingdom.

In Sweden, accelerated training has been arranged, consisting of a minimum of ten hours of lectures followed by practical work, for those midwives who graduated from midwifery school before 1973 (when the teaching of family planning was strengthened).

In the United Kingdom the "900 course" helps fill in the gaps in university courses that are timorous where family planning is concerned.

In the Netherlands additional training of the same type gives midwives practising in hospital centres the knowledge needed to exercise responsibilities for day-to-day interventions at family planning centres.

Conclusions

In conclusion, irrespective of the country's health policy the importance of family planning is nowadays recognized by governments, medical schools and schools of nursing and midwifery. This is for a number of reasons, *inter alia:*

- the world population explosion;
- the realization of the need to ensure health and vitality for women and children;
- the need for and importance of reducing the number of abortion requests.

As all these "findings" have been understood and clearly stated in most of the countries visited we should sum up by asking two questions:

- does the present distribution of functions and responsibilities make for an optimum "yield" in services designed for women, married couples and children?

— is training in family planning in universities and at nursing and midwifery schools in line with the real needs in the field?

With regard to the first question it is clear that, in order to arrive at a better understanding of the problem as a whole, the distribution of tasks and responsibilities relating to family planning must be drawn up. This varies widely from one country to another.

— In *France*, family planning is beginning to be really taken over by the State. General practitioners and specialists are in charge of technical aspects while the functions of the midwife are limited to the provision of information. For the moment the nurse has only a negligible role.

— In *Italy*, family planning is only in the experimental phase but the infrastructure is being set up very fast, in particular in northern Italy (Bologna) where public health nurses are to have an important role.

— In the *Netherlands*, 95% of all family planning, at least in its purely technical aspects (contraception), is provided by the general practitioners. Nurses/midwives working in hospitals have in recent times taken over responsibility for oral contraceptives and for IUD insertions.

— In *Poland*, contraception is in the hands of the gynaecologist and obstetrician while the midwife acts as technical assistant; the public health nurse has a real role only in rural areas.

— In *Sweden*, there is an even distribution between the general practitioners and midwives, responsible for 56% of contraceptive activities; as in the Netherlands and the United Kingdom the gynaecologist and obstetrician act as consultants.

— In the *United Kingdom*, general practitioners, and in particular family planning physicians, are very active but health visitors are responsible to a large extent for services in this field; for the moment they do not have the right to prescribe.

— In *Yugoslavia*, it is the general medical practitioner who has the key role, while nurses and midwives both act as informants at family planning centres.

To deal with the essential tasks of family planning (i.e. counselling in contraception, sexuality and conjugal problems), *better distribution of responsibilities* would seem to be desirable in some countries along with *better training* for the different categories of personnel in charge of family planning.

As has already been stressed, the narrow scope of the study in question, limited as it was to medical, nursing and midwifery schools, should not lead

us to ignore the fact that family planning remains a *team task*, where psychologists, social workers, lawyers, etc. all have an essential part to play.

With regard to the second question, i.e. whether training in family planning at universities and nursing and midwifery schools meets real field needs, there can be no single reply but rather a number of answers, each one resulting from the way family planning systems operate in the different countries.

For example, although the teaching of family planning does not seem to be adequate in the Swedish universities, in practice this is a deliberate choice in line with the decision to give priority to student midwives in allocating field work places at family planning centres. In other countries, the same type of teaching appears to be clearly in short supply, given the responsibilities for it allocated to medical practitioners.

Complementary study on the teaching of family planning

M. Péchevis

At the beginning of 1981, a study was undertaken to collect information on the present teaching of family planning (basic education and refresher training) for different categories of health personnel in the countries represented at the conference but not included in the study carried out in 1978 at the request of WHO.[a]

Out of the 13 countries contacted, ten replied to the questionnaire: Algeria, Belgium (midwives and nurses), Bulgaria, Egypt (training of midwives and nurses), Hungary, Portugal, Spain, Tunisia, Turkey and Yugoslavia. The questionnaires were sent out to offices responsible for the training of personnel at ministry of education (in particular for physicians) and ministry of health levels. In addition, some teachers were contacted directly.

Results of the study

Role and responsibilities of different categories of personnel (Table 4)
General practitioners act as informants on family planning in almost all countries included in the study. Moreover, in most countries they are in charge of prescribing "medical" contraceptive methods, in particular the pill, and of monitoring and supervising contraception. In Turkey, one of their tasks is to supervise the midwives.

Gynaecologists and obstetricians obviously have a more extensive role and appear everywhere to act as "technicians" in the family planning sphere. Their role in Turkey in supervising general practitioners and midwives is also noteworthy.

[a] Unpublished WHO document ICP/MCH-UNFPA/RER 72/PO9.

Table 4. Role and responsibilities of different categories of personnel

Role and responsibilities in family planning	Categories of personnel						
	Medical personnel						
	General medicine	Gynaecologists and obstetricians	Others	Midwives	Nurses	Social workers	Others
Information/counselling	+++	+	paediatricians	+++	+++	+++	pharmacists (Tunisia) psychologists (Hungary)
Record-keeping				+ (Egypt)	+ (Egypt)		
Prescription of "simple" methods				+ (Tunisia)			
Prescription of the pill	++	+++					
Distribution of pills				+ (Egypt)	+ (Egypt, Turkey)		
Doctor's assistant				++			

Table 4 (contd)

Surveillance/monitoring	++	+++			
Referral to specialists	+ (Spain)				
IUD insertion		+++	+ (Turkey)	+ (Turkey)	
"Surgical" methods		+++			
Supervision	+ (Turkey)	+ (Turkey)			
Education of schoolchildren	+ (Hungary)				
Counselling in the social and legal sphere					"specialized surgeries" (Bulgaria)
Disturbances to the sex life					sexologists (Spain)

+++ = all countries ++ = some countries + = one or two countries

Among the other medical specialists, it is the paediatrician who is referred to most frequently, his role being basically at the information level.

In most of the countries midwives act as informants and provide education in family planning matters, with only a few countries giving them an active part to play where they prescribe "simple" contraceptive methods or distribute pills. In Turkey they are beginning to be involved with IUD insertions.

Nurses have more or less the same roles s midwives. It should be noted that in Hungary midwives and nurses have no specific responsibilities in family planning. In Belgium only "graduate social nurses" have a major part to play in family planning.

Social workers are the category most frequently referred to as counsellors in everything related to family health.

In practice, as has been noted by some workers, in those countries with no precise family planning policy roles vary very widely and depend on the interest displayed by members of the health professions in family planning and on their individual awareness of the problem.

Basic medical education (Table 5)

The amount of time devoted to the teaching of family planning ranges between 4 and 20 hours depending on the country studied (theoretical teaching). Practical training should also be added (clinical work whose duration and content is not given in precise detail).

Teaching is by and large concerned with technical aspects (studies of different contraceptive methods) and sterility. On the other hand, psychological aspects, sexology and abortion are much less frequently specifically attended to in teaching. Such teaching is generally integrated with other subjects and in most countries takes place during the fourth or fifth year of medical studies. In Portugal, however, it is spread over four years from the third to the sixth year of study.

Training of specialists

It was not possible to obtain precise information on the training of gynaecologists and obstetricians in family planning. There are wide variations from one country to another and the importance attached to training in this field depends on the interest displayed in it by teachers and students. It is a noteworthy fact that in Hungary teaching of different aspects of family planning is combined together in a two-week course.

Future paediatricians receive some training in family planning in some countries (Bulgaria, Tunisia). For other specialties (cardiology, psychiatry), family planning remains an optional subject.

Basic training of midwives and nurses

The amount of time devoted to the training of midwives in family planning ranges between 2 and 10 hours depending on the country and this training is given as part of training in other fields. In Algeria it remains an option, as part of the six hours set aside for "organization of MCH" and therefore depends on the interest of instructors and teachers. Technical aspects are

Table 5. Training of medical students: teaching of family planning in medical schools

Topics in or aspects of family planning	Algeria	Bulgaria	Hungary	Portugal	Spain	Tunisia	Turkey	Yugoslavia
Study of the various contraceptive techniques	yes 4th year	4 hours 4th year	2 hours 4th year	3 hours 5th year	7 hours 4th year	6 hours 5th year	— 4th year	2 hours 4th-5th year
Psychological aspects of family planning			1 hour 4th year	2 hours 5th year			— 1st year	6 hours 4th-5th year
Abortion		4 hours 4th year	1 hour 4th year	Not stated		2 hours —		2 hours 4th-5th year
Sterility	yes 4th year	4 hours 5th year	1 hour 4th year	2 hours 5th year		4 hours —		4 hours 4th-5th year
Disorders of sexology (including sex life)		2 hours 5th year		3 hours 6th year				1 hour 4th-5th year
Demographic aspects of family planning		2 hours 5th year		1 hour 4th year			1st year	1 hour 4th-5th year
Listening and conversational techniques in family planning				Throughout the family planning course 5th year		Discussions during service meetings		3 hours 4th-5th year
Other aspects								
— contraceptive pharmacology				3 hours 3rd year				
— sexually transmissible diseases	yes 4th year							
No. of hours								
— theoretical	(4)	16	5	14	7	6 or 12	12-20	
— practical	(2)	yes	yes	yes — 40	no	yes	yes	

dealt with on a regular basis but psychosocial aspects, sex education and training in listening and conversation seem to be by and large absent from this type of training in most of the countries.

At the same time it is often difficult to understand the importance given to and the exact content of training in family planning, as it is combined with training in other wider disciplines such as "obstetrics, hygiene and nursing care" and "psychology and teaching methods", as in Belgium, or "gynaecology and obstetrics", "health and health education" and "psychology", as in Yugoslavia.

Generally, the basic training given to nurses in family planning has the same characteristics.

Continuation and refresher training

This is the level where family planning teaching appears to be at its most developed.

In Algeria, multidisciplinary specialized courses lasting one month have been held regularly since 1974 by the Central Office for Maternal and Child Protection, in order to integrate birth spacing activities with those of maternal and child health. In practice it is the only complete family planning training scheme existing in the country.

In Portugal, there are multidisciplinary refresher training courses (for physicians and public health nurses) arranged by the Directorate General of Health, lasting 1–2 weeks and covering the chief aspects of family planning. One-day seminars are also held at local level on specific subjects. Continuation training is generally provided by other agencies such as the gynaecology department of the University Hospital of Lisbon, the Portuguese Gynaecology Society, the Portuguese Paediatrics Society, the Psychiatry Society and the Portuguese Medical Association. Various aspects of family planning are dealt with during other congresses or meetings on more general subjects such as adolescence or family health (Table 6).

In Tunisia, courses ranging from one month to six months are held by the Centre for Continuation Training in Family Planning, under the auspices of the National Office for Family Planning and Population. They either cover all aspects of family planning or single out specific individual features such as reception, discussion techniques, supervision, administrative matters, education, contraceptive methods or coelioscopy. Some of the sessions are multidisciplinary, while others are reserved for a single category of personnel (physicians, midwives, educators, regional family planning officers, etc.), depending on their responsibilities in the family planning sphere (Table 7).

In Turkey, the General Directorate of Population Planning (GDPP) holds courses varying in length from two days to four weeks and dealing with different aspects of family planning. These sessions are generally monodisciplinary and mandatory for physicians dealing with family planning in the public services (Table 8).

Some countries have not yet arranged refresher or specialized training courses for their family planning personnel, at least at central level. This is the case for Spain.

Table 6. Refresher and specialized training of health personnel: teaching of family planning in Portugal

Subject of course	Responsible agency	Length	Participants
Adolescence			
Contraception in the adolescent girl Pregnancy and adolescence	Gynaecology department, Lisbon University Hospital	2 days	Some 200 participants (physicians, gynaecologists, psychiatrists, nurses, social workers)
Established contraceptive techniques			
(Results, possibilities for changes)	Portuguese Gynaecology Society	1 day	Gynaecologists and gynaecology trainees
Teaching of family planning			
(Round-table on occasion of congress)	Medical Association	1 half-day	Open to all members of the Association
Family health			
(Including family planning)	Psychiatry Society Portuguese Paediatrics Society	5 days	Open to all interested physicians

Table 7. Refresher and specialized training of health personnel: teaching of family planning in Tunisia

Subject of course	Responsible agency	Length	Participants	Comments
Reception at family planning centres	ONPFP[a] training centre	1 week	Physicians, midwives, social workers, nurses, nursing assistants	For reception, an effort is made to use staff from a single given health centre
Administration and management of family planning staff	ONPFP	2 weeks	Regional family planning officers, midwife supervisors	
Education in family planning	ONPFP	2 weeks	Regional health educators, midwife supervisors, social workers, male nurses	
Community approach to family planning	ONPFP	1 week	Regional officers, physicians, midwives, social workers	
Discussion techniques and training methods for family planning	ONPFP	4 days 2 weeks	Educators, social workers Physicians, educators, trainers	
Supervision of family planning services	ONPFP	2 weeks	Midwife supervisors, regional family planning officers	
Training in family planning	ONPFP training centre	6 weeks	Practising midwives	2 weeks' theory and simulated practice 4 weeks' actual practice
Introduction to family planning	ONPFP training centre	10 days	Midwives graduating from schools	Immediately after graduation

Table 7 (contd)

Subject of course	Responsible agency	Length	Participants	Comments
Coelioscopy training	ONPFP	3 weeks	Gynaecologists	International programme 1 week s theory 2 weeks' practice
Coelioscopy training	ONPFP	2 weeks	Operating-theatre nurses	International programme 1 weeks' theory 1 weeks' practice
Training in family planning (birth-spacing methods)	ONPFP	3 weeks	General practitioners	1 weeks' theory 2 weeks' practice
Family planning, prevention measures	ONPFP	1 week	Nurse hygienists	
Integration of family planning at health schools	ONPFP	1 week	Principals and instructors at schools	

[a] ONPFP: National Office for Family Planning and Population

Table 8. Refresher and specialized training of health personnel: teaching of family planning in Turkey

Subject of course	Responsible agency	Length	Participants	Comments
Communication techniques in family planning	GDPP[a]	5 days	Physicians	Theoretical and practical course on the use and maintenance of audiovisual equipment
Leadership techniques Family planning Maternal and child health Collection of data, record-keeping	Provincial family planning administrations (by nursing instructors)	5 days	Supervising nurses	Field work and theoretical course
Family planning Maternal and child health Record-keeping	Provincial family planning administrations (by nursing instructors)	2 weeks	Rural midwives	Field work and theoretical course
Health and administration Programme management	GDPP	2 days	Provincial directors of health	Orientation course in family planning/maternal and child health
Leadership techniques Data collection, record-keeping Integrated family planning/maternal and child health departments		5 days	Provincial directors of family planning	Orientation course in family planning/maternal and child health
Endoscopy Family planning Reproductive health Techniques in endoscopy	GDPP in collaboration with 5 teaching hospitals	3 weeks 2 weeks 1 week	Gynaecologists and obstetricians Operating-theatre nurses (instructors) Operating-theatre nurses (instructors)	1 week's theoretical course 3 weeks' clinical teaching Inservice training and theoretical teaching
Social and health aspects of family planning	GDPP		Guidance of public officials, religious leaders, primary school teachers	

Table 8 (contd)

Subject of course	Responsible agency	Length	Participants	Comments
IUD insertions	GDPP training centre	21 days	General practitioners	Clinical practice and theoretical training
Why family planning? Reproductive health Contraceptive techniques Record-keeping	GDPP training centre	3 days	Gynaecologists and obstetricians	Clinical practice and theoretical training
Ditto	GDPP training centre	4 weeks	Nurse/midwives and midwives	Clinical practice and theoretical training
As for physicians, including leadership techniques	GDPP training centre		Head midwives at regional level	Supervision of qualified midwives
Health administration Community health Maternal and child health Family planning Field work Family planning clinical practice	GDPP in collaboration with the Gulveren Family Health Centre and the Gevher Nesibe Institute of Health Education		Nurse instructors at provincial level	

[a] GDPP: General Directorate of Population Planning

Conclusions

Training of different categories of personnel in family planning appears to vary widely from one country to another and, within a single given country, from one faculty or school to another.

The importance attached to such teaching frequently depends on official policies in this area and on its ranking in priority terms. A broad margin of freedom is left to teachers and the amount and quality of teaching then depends on the interest they have in the subject.

Scarcely any mention was made in the replies to the questionnaires of training of health auxiliaries. Their training in family planning, as in other priority fields, is however crucial because in many countries it is they who have much of the responsibility at the primary health care level.

Basic training is generally speaking very limited (as is shown by the preliminary tests that participants in refresher or specialized training courses have been asked to take in various countries).

Continuing education and refresher training are thus of vital importance in training health personnel and make it possible to offset at least some of the shortcomings in basic training. Refresher training has other advantages. If courses are multidisciplinary, they form an excellent basis for teamwork, which is one of the keys to success in family planning activities. In addition, they are a flexible approach, allowing the needs of different kinds of staff to be catered for, and are obviously irreplaceable as a means of updating knowledge. However, this does not mean that the need to develop teaching as part of basic training may be ignored, as integrated teaching is the best groundwork for integrated activities.

Summary of discussions

The data are not very comparable from one country to another. If they are to be analysed, it is important to bear in mind:

- the way such questions are handled in the country: political choices, religious, cultural influences, etc.;
- the goals of teaching and the reality of the teaching process: integration in hospital practice or not, etc.;
- the types of personal motivation of those responsible for teaching.

The problem of division of labour arises in different ways in different countries:

- in developing countries as many jobs as possible must be given to auxiliary personnel, and family planning must be integrated with every other health sector: MCH, hygiene, nutrition, education, etc.;
- in the industrialized countries the overmedicalization of contraception is often questioned.

The present trend is towards the integration of family planning teaching with the basic training in the various branches of the health professions: midwives, physicians, etc.

2

Introduction to aspects of family planning

Problems in the teaching of family planning and sexuality

M. Manciaux

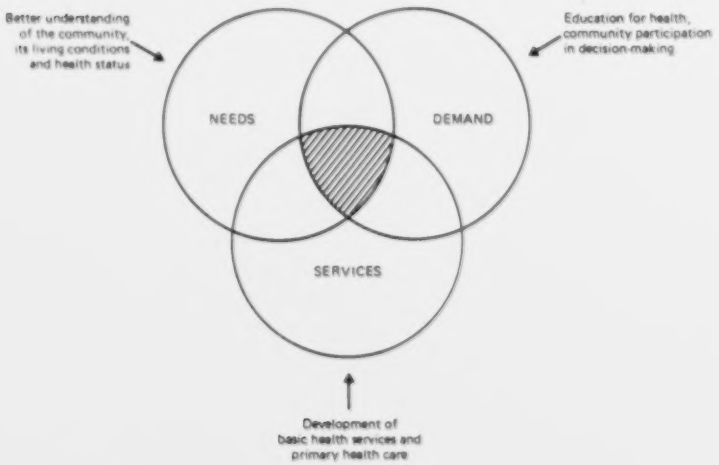
Terminology is not a neutral matter and the proposed title is scarcely likely to be the best. "Teaching" attaches too much priority to the passive transfer of knowledge whereas it would be better to stress active training in the different areas of education: knowledge, attitudes and aptitudes. "Family planning" refers to a given situation or framework which, despite the numerous sociological models that can be recognized in it, seems prescriptive if not simply sententious. Perhaps it would be better to treat it simply as training in fertility control. After all, it is a matter of the training to be given to personnel "either during their basic studies or after qualifying", so they are in a position to carry out their professional responsibilities in this field.

It should first of all be noted that, as in many other aspects of the training of medical and health personnel, two worlds rub shoulders without really meeting: the world of action programmes and services and that of training programmes for those who are to be in charge of implementing and organizing the former. When teaching goals for faculties and training schools are being drawn up, reference is hardly ever made to the health policy of a country, its options or its health code. With the exception of the university hospital, insufficient use is made of the existing public health infrastructure in the practical and clinical training programmes for future members of the health professions. The evaluation of students rarely answers the crucial question as to whether the trained student is capable of taking his place in his country's health system and working effectively in it in line with the country's health planning.

There are numerous examples of this lack of communication or meeting between the two needs, and a single governing authority for education and health is not enough to bridge the gap, although it can be of assistance in maintaining contact. Here too, a change of attitudes is needed which would call in question the goals themselves and the methods of achieving them in the training of health professionals.

In Fig. 3 consideration of the insufficient intersection of the three circles "needs—demand—services" can be of great use provided it is based on a proper knowledge of specific situations and it is first applied to analysing the needs—demand—services sequence in family planning, before being used in relation to training in this field. Worthwhile lessons may be drawn from a study of the areas of insufficient overlap between the different circles displaying dissatisfaction, frustration, underuse of services, activities to be undertaken to improve the degree of interaction (education for health, consciousness raising, decentralization of activities, and the delegation of responsibilities are of capital importance here) and to achieve a regular evaluation of progress in services and training. However, very few examples are known of an approach to the problem that is so rigorous.

Fig. 3. Needs, demand and provision of health services


Better understanding of the community, its living conditions and health status
Education for health, community participation in decision-making
NEEDS
DEMAND
SERVICES
Development of basic health services and primary health care

Areas of overlap for needs, demand (expressed needs) and services provided, with arrows indicating the action to be undertaken in order to increase the area. The three areas of partial coverage correspond to the following situations:

1	Needs existing, demand expressed, no services available	→ discontent
2	Needs existing, services existing, no demand expressed	→ underuse
3	Demand expressed, services existing, no real need	→ ineffectiveness wastage

Source: **Mancioux, M.R.G.** *Maternal and child health: future problems and factors involved in their solutions.* Working paper (MCH/WP 75.6) submitted to the WHO Expert Committee on New Trends and Approaches in the Delivery of Maternal and Child Care in Health Services, meeting in Geneva (Switzerland), 9-15 December 1975.

There are surely very few spheres of science and human practice where such an utter lack of knowledge and such a wide cleavage between existing knowledge, attitudes and practices can be observed. This may be because sexuality is a matter that goes deep into the innermost part of our being, individual and collective behaviour and human relations, and because it forms so profound a part of our subconscious. Here too clear-minded analysis is called for, both from the point of view of the existing situation (KAP surveys, for example) and of teaching methods (what knowlege is transmitted and how it is transmitted). Other papers will deal with some aspects of this, but let us say here that it will never be possible to reason over matters related to training in fertility control in the same way as is done for the teaching of molecular biology or the information sciences. A philosophical approach and thorough consideration of the subject may be of use so long as what is specific and what is the fruit of experience are not thrown away and no attempt is made to bend the facts to fit the demands of doctrine. Both in the practice and in teaching of family planning we have a great need for specialists in communication. But are not teaching methods themselves first and foremost a matter of communication, so long as they are properly understood?

Finally, any such deep consideration is only worthwhile if it helps us to pass from problems to programmes. Even if all problems of concept have not been solved, we must still undertake programmes: family planning programmes for communities that demand them of us and rightly so; and educational programmes to train health personnel to organize action programmes. Beyond the few examples we have given in the present review, the preparation of training programmes is the very crux of the present conference in the same way as it is at the heart of the concerns of the International Children's Centre. Joint reflection and exchange of experience should help us move forward together in this sphere.

Strategy for teaching human reproduction and family planning

P.O. Hubinont

Introduction

The physician's position in society has varied widely over the centuries and the way medicine has been taught bears witness to the fact.

In other words, medical education has to take account of the type of physician expected by society and to fit in with such a demand, if it is to be able to perform its role properly. The same thing is true for the other health professions.

Traditional medical education based on the study of natural sciences, followed by training in basic medical sciences and pathology, and the observation of patients in hospitals, has long since ceased to be enough, because it does not prepare for the contingencies of general medical practice, the requirements of preventive medical care or the integration of the physician in the community. The latter therefore does not receive all the services

it is entitled to expect of those it has invested in and whose overheads it has more or less directly supported through a number of years of study.

This is neither the place nor the time to develop these preliminary remarks, which were nevertheless worth making in order to provide the framework for what follows.

If health is a state of complete physical, mental and social wellbeing (and not merely the absence of disease or infirmity), then among the professions contributing to it the medical profession has the function not only of combating the causes of disease and death but also of preventing them as far as possible and promoting the wellbeing of those it is responsible for.

Even more, it should be said as a counsellor as much as an intervening agent (or both as counsellor and intervening agent to the same degree), the health worker is the repository of science as a service and is not entitled to use science with the more or less explicit design of oppressing or exerting his power over others.

In the part of the world where I live, medical education leads to the training of technicians who have extraordinary techniques and knowledge at their disposal and whose practices are largely concerned with solving problems while generally speaking omitting to involve the patient as a participant.

While the emergence of such an attitude may be understood in the "grand" medical disciplines such as resuscitation, cancer treatment and emergency surgery, where the patient's role is often ignored because of the intensive care to be provided and the gravity of the case, it is nonetheless inexcusable. The *great* doctors are in any case those who have understood this and do everything to involve the patient, sharing the responsibility for arriving at informed decisions.

This sharing in no way diminishes decision-making or detracts from medical responsibility but leads to a continuation of dialogue between the holder of knowledge and the beneficiary.

In another sphere, it may be asked whether medical education is doing its job when it leads to the establishment of a caste that tends to try and preserve its privileges while isolating itself in a way that is tantamount to setting itself apart from society and constituting a reactionary pressure group.

Clearly, the sphere of human reproduction is one where the gap between medicine and the community can do the most damage.

After all, it was not very long ago that prominent medical authorities were known to state that family planning (and in particular voluntary termination of pregnancy) had nothing to do with medicine, when we know that it is one of the most significant parameters for family health in particular and public health in general.

If we consider the information forming part of the teaching of human reproduction in the context of the programmes of most medical schools, we will see that it is touched on, but in most cases only as part of the teaching of natural sciences, basic medical sciences or pathology, and in any case in a generalized fashion, without any apparent link between the various disciplines.

This was why ten years ago the medical faculty I belong to was led to incorporate in its programme of *preclinical* studies 15 hours of teaching (one semester) of an "Introduction to human reproduction", covering concepts already taught in courses of anatomy, histology, physiology and biochemistry with regard to the biological mechanisms governing reproduction, and introducing matters related to sexology, birth planning, and the psychological and sociological aspects of the problem, and giving a preview of subjects to be dealt with during clinical teaching.

This teaching is arranged by a clinician who returns to the same students during the fourth year to teach them gynaecological semiology and later gynaecological pathology and clinical aspects of gynaecology and obstetrics.

Five years ago, the author introduced, on a trial basis in the fifth year, courses in social gynaecology during which students are brought into contact with pregnant women, accompany social health nurses on home visits and take part in family planning consultations. This activity has not so far been brought into general application but is of considerable interest for future physicians.

In a world where human reproduction is creating ever-growing problems and where it is more and more widely accepted that the aim should not be for the fertility of a couple to lead to the procreation of all those children that could be born as a result of sexual activity, but rather to obtain control over fertility in such a way as to bring into the world the number of children (and with the best possible spacing) that the couple is ready to care for until the onset of adulthood, members of the health professions and in particular the medical profession must have a proper preparation for their role as guides, mentors and technicians in family health.

Various studies analysing the motivation of young women and young men taking up the health professions have shown that first and foremost they are striving to establish for themselves a self-image where their concern to provide devotion, solidarity and respect for others may be given free rein. It is to this goal that medical education must contribute.

Finally, if consideration is given to the fact that in the sphere we are discussing here, future doctors, midwives, nurses of both sexes and social workers will face problems that they were not in a position to resolve on their own, teaching (whatever its direction and technique) must provide the necessary support.

Pattern for integrated teaching of human reproduction and family planning

In the specific example of the "Introduction to human reproduction" described above, which consists of 15 hours of theoretical teaching during preclinical studies, an attempt has been made to bring together biological, sexological, sociological and preventive matters. The following subjects are taught in this course.

Biological aspects

— formation of male and female gonads

— genetic determination of sex

— spermatogenesis
— neurophysiology of ejaculation
— biochemistry of seminal fluid
— transport of gametes in the female genital tract
— menstrual cycle, growth of the follicle and ovulation
— the hypothalamus-hypophysis-gonad axis
— fertilization and formation of the blastocyte
— migration of the ovum and implantation
— formation of the placenta
— development of the embryo and of organs
— childbirth
— lactation in relation to return of fertility

Sexological aspects
— criteria for sex determination
— anomalies of development: intersexuality
— child and adolescent sexuality
— independent stimulation governing erection and orgasm
— sexual stimulation and response
— sexual attitudes and behaviour
— sexual minorities
— geriatric sexuality, menopause and castration

Sociological aspects
— family health
— demography and health
— psychosocial obstacles

Preventive aspects
— inventory of birth spacing methods
— method of use, acceptability, effectiveness, relationship between cost and use
— sex education and health education
— premarital and marital advice and marriage counselling
— prenatal and postnatal surveillance
— service organization models; role of the health professions

All this is preceded by teaching of psychology and training in medical sociology, in addition to conventional teaching of the morphological (anatomy, histology, embryology), physiological and biochemical sciences.

Aspects of training in the field

The most frequent reproach directed at schools of medicine, nursing and midwifery is that they are too conservative, promoting copious scholastic education but limiting practical training to periods of hospital practice and restricting the approach to health problems to curative aspects of medicine and nursing care.

This very widespread shortcoming is a damaging one. On the one hand, it fails to take into consideration the considerable interest generated by active teaching and participation of the student in the acquisition of knowledge and on the other, it fails to take account of the sociological and psychological dimensions of health problems in the community as a whole.

In the past one or two decades, it is true that medical education and care institutions have tended to become more open to the community, but the phenomenon is far from being very widespread and the trend is extremely slow.

In the case we are concerned with, the shortcoming is catastrophic since it produces a situation where all that the community has available to it are medical practitioners, nurses and midwives with only a rudimentary experience in problems concerning all of adolescent and adult mankind, from the onset of fertility to its cessation.

The measures to be taken are general ones and presuppose a revision of educational programmes in teaching and training institutions for health professionals in such a way as to stress the balanced acquisition of theoretical information and practical skills that may be applied straight away for the benefit of the community and the individuals it is composed of.

This presupposes an effort at integrating faculties and schools within the community, selecting periods of training "in the field" rather than in closed institutions, getting rid of certain superiority or inferiority complexes hampering communications among the professions and, in their place, creating an atmosphere of solidarity and fellow-feeling where the team spirit may develop and flourish.

Conclusions and summary

Various factors have to be taken account of in developing a strategy aimed at providing the proper training in the field of family planning.

(*a*) Although scientific information is necessary, there are a series of psychological and sociological barriers hampering access to it and preventing reception of it by the taught if not by the teachers. These barriers are grounded in deep-rooted habits and convictions found in numerous cultures in different shapes resulting in puritanism with regard to sexuality.

(*b*) The health problems raised by sex life and the reproductive function involve individuals deeply in the innermost part of their being. This means that those health workers whose function it is to suggest solutions and assist in their implementation must not only have the proper academic and practical background but must also have had the opportunity to solve their own problems in the best possible way.

(*c*) Sexual and reproductive activity forms part of life as a whole and there is no real reason for the related preventive health care to be dealt with in isolation from preventive maternal and child health care. On the contrary, there are many arguments for integration in relation both to teaching and to the organization of services:

— with regard to teaching, it is enough to proceed from the simple principle of treating contraception as the mirror image of fertility;

— with regard to the organization of services, there has been a clear demonstration of the potential benefit in terms of effectiveness resulting from integrating contraception with maternal and child health care services.

It is essential not to lose sight of the fact that the life of a couple, and particularly that of the woman, is a continuing phenomenon which it is important to keep in perspective.

Reproductive potential and, more and more, sexual activity begin with the onset of puberty and carry on for several decades. This fact should not be lost sight of and there are no grounds for giving separate treatment to adolescents, women without children and those who have had a number, or for separating medical treatment of women from that of children where family health preventive measures are concerned.

(*d*) When we speak of integration, we presuppose a multidisciplinary and all-round approach. Teaching must therefore aim at training the health professions for teamwork, at least where its field applications are concerned. Teamwork requires not only good human relations but also presupposes a common background of doctrine and integrated information. The latter could be based on a common body of knowledge for the different qualifications.

The social status of women and family planning in developing countries

M. Ladjali and F. Oussedik

The aim of this paper is to present some ideas about the social status of women and family planning in developing countries based on an example from the Maghreb in North Africa. The concepts underlying these ideas should first be defined.

"Social status" means all the functions of a person in a given society. Birth spacing relates to women in their function as reproducers of humankind. Fertility is therefore just one aspect of their status as a whole.

In its conventional definition, family planning brings two main components into play: on the one hand, the medical component, consisting of those methods that enable undesired pregnancies to be avoided and the other, a more social dimension, which adds to a deliberate selection of the number of pregnancies, various activities ranging from treatment of sterility

to sex education and to marriage and genetic counselling. In developing countries, a further economic component is added because the family income is influenced as a result.

Family planning should therefore represent a deliberate act whereby a woman establishes a relationship between family size, family income and the sociocultural circumstances she lives in. It is only by linking these three variables that family reproduction can be regarded as an index of a social future that has been brought under total control.

In Algeria, what is the place of the woman in family planning? More precisely, what is her position in relation to family size and to the economic resources of her family? We intend to use the definition we have just given in order to establish the place of the woman in family planning. It will be a matter of asking ourselves what her position is in relation to this definition of family planning.

Three points will be given particular attention:

— economically, the place of the woman in the creation of the family income;

— medically, control over family size in relation to fertility and infant mortality;

— socioculturally, the conditions enabling a woman to link her place in the family income to control over her own fertility. This latter point will make it easier for the relationship of women to population policies to be grasped.

The place of the woman in creating family income

The problem of working women is still the subject of theoretical discussion which may be briefly summarized in the following two statements.

— The definition of the concept of housework based on a critical analysis of the concept of productive work. Women in the household are outside the system of so-called productive labour. Efforts are being made to consider housework as true productive labour. This matter is still under study.

— Acknowledgement of the position of women in wage-earning employment. This is the problem to be considered as it is the only one at present given social acknowledgement.

For this reason, in the present paper only the place and structure of female labour in developing countries will be taken into consideration.

In Algeria, for example, according to the 1977 census, out of a theoretical population of working age (15–65 years) of some 8.5 million, only 2.5 million were in effective employment, including less than 200 000 women. This means a proportion of 8.9%, i.e. scarcely more than the proportion found in the 1966 census. It should also be clearly noted that the percentage is calculated in relation to the active population. As a whole, it amounts to 3.3% of women of working age.

With regard to the structure of employment, since 1966 there has been a fall-off in salaried female farm workers and home workers and a stagnation in the number of female textile workers, while the number of women working in other industrial sectors and, in particular, in the administration and community services has been increasing.

Although 46% of women out at work now have school-leaving qualifications (as against 15% of men), the almost total absence of women in senior positions in the system will be noted.

Another traditional feature is the fact that one finds very few women in jobs requiring constant contact with the public: office counters, the hotel trade, restaurants and catering, etc. The distribution of functions between men and women, without remaining exactly as it was in the old days, is still clearly stamped by tradition.

The number of working women remains low: 6 for every 100 men.

Thus, men have the priority in terms of jobs as they alone are viewed as heads of families, a factor reinforcing social oppression: the woman is subject to domination by the male who holds the keys as breadwinner for meeting the family's needs.

In conclusion, it may be said that women have an insignificant position in the creation of a family income.

Control over family size in relation to fertility and infant mortality

In 1979, 60% of all births in Algeria still took place in the home. This explains the high rate of birth-related mortality and morbidity. Study of such mortality according to age shows that it is more serious among women at the two opposite extremes of fertility: between 15 and 25 years of age and 35 and 40 years of age. In 1972, out of 97 800 births, perinatal mortality reached 3.5 per thousand women hospitalized in maternity wards, i.e. 20–50 times higher than in well-off countries. Pregnancy and delivery cause major maternal morbidity, and this is more frequent among mothers of large families. The main causes of hospital morbidity were identified in 1972: out of 100 000 hospitalizations of women, a high percentage were due to complications during pregnancy or delivery, or postpartum; such complications affected one fifth of all women below the age of 20, one third of women between the age of 20 and 44 and 10% after the age of 45.

Infant mortality is also high. Conditions associated with the pregnancy of the mother and delivery are a cause of 85% of deaths among infants aged less than one month.

Infant mortality was still as high as 115 per thousand in 1978, and now stands at 105 per thousand. Factors in infant mortality include:

— Low birth weight and premature birth. These factors involved in mortality and future morbidity are predominant among children of mothers with large families.

— Illiteracy among the mothers. It has been demonstrated that infant mortality falls as the level of education of the mother increases.

— Malnutrition, which is more frequently encountered amongst large families and is, in reality, the true cause of high mortality rates. When one child is born shortly after another, it has a bad start in life because the mother is undernourished. Moreover, when he or she is displaced by a younger sibling, it often happens that there are not enough substitute foods. This sets off malnutrition with its accompanying train of interconnected or exacerbated illnesses: measles, whooping cough, dehydration, etc.

— Finally, the age of the mother. Infant mortality is higher among children of women aged under 20 years or over 35 years than in other age groups.

Numerous studies have shown that the chances of survival (except for the first child) are higher when the interval between conceptions is wide. Infant mortality declines if births are more widely spaced.

The overall rate of general fertility has been estimated at 203 per thousand in 1978, i.e. 1000 women of procreative age produced an average of 203 children. This rate rises to 306 if the legitimate birth rates are considered, i.e. 1000 married women of procreative age produced an average of 306 children. The average number of children per woman is seven.

At the same time, the prime feature of the marriage rate is its level and the early age at which marriage takes place. The marriage rate is 98.2% in urban areas and 98.8% in rural areas. Moreover, in 1978, 35.5% of all women were married at less than age 19 and almost 96.6% at less than age 30. By the age of 20, one woman out of every two and one man out of every ten had already contracted a first marriage.

The still quite low average age of marriage combined with early deliveries means a very long fertile life during which reproductive activity is practically uninterrupted.

All the foregoing means that the woman is hemmed in within her so-called "natural" functions while no account is taken of the way her body is being wasted. This results in an intensive exploitation of her natural functions, which strengthens the exclusion of women from other social activities.

Women are thus potentially excluded from the productive sector and confined within that of reproduction; and high maternity rates contribute to this process. It emerges from a 1980 national survey of the typical acceptor of contraceptive methods requesting family planning services for the first time that she is above all from an urban environment and has already had five children by the time she attends for consultation. Thus, birth spacing services are not provided as part of family planning organized from the very onset of fertility but as one of a number of therapeutic actions initiated to assist exhausted women. Medicine finds itself trapped in an inheritance of problems originating in the way society is organized, and the enclosure of women in the single dimension of motherhood. In reality, medicine puts up with a situation that is not of its own making. Moreover, some population

policies seek through medical actions to reduce reproduction rates by control over the female uterus and negation of the persons they belong to.

The true answers to the problem of family planning will only be provided by a change in the social status of women. Their fertility is an expression of only one of their different types of status. Certain value systems have crystallized around woman the traditions that have reduced her to the simple role of reproducer with a large part of her life being devoted to pregnancies and the raising of children.

If a family planning policy is to succeed, it is not enough to distribute contraceptives accompanied by instructions for use; it is essential for women to follow them. For women to consciously participate in controlling fertility, a change must take place in the role traditionally allotted to them. If they are relegated to the role of child minders and to traditional roles, they lose any possibility of finding work or engaging in political activity.

The different problems raised in the foregoing show the importance of family planning as defined in terms of improving the quality of life. For a family planning policy to be realized, women must be conscious supporters of it. This presupposes altering their social status through recognition of other functions that they must or want to perform, as direct producers and as citizens.

Role of the woman in family planning

D. Nardini-Maillard

The aim proposed here is to consider the role of the woman first as an individual and secondly as a being with sexual prerogatives of her own.

This distinction seems of prime importance because it contains the rough outline of a reply to the questions that will be asked, i.e. that women cannot be relegated to the reproductive function alone no matter how important that may be, despite the fact that it is a function physiologically proper to them; they are entitled to fully-fledged status as individuals and therefore as social beings.

This is really the only way of allowing a woman to see something other than repeatedly giving birth as the sole form of existence, personal richness and social respectability.

We must stress, however, that it is not a question here of providing answers to the complex problem under discussion at this conference but rather of attempting to ask those questions that might help to stimulate joint thinking on the matter.

If we speak of women, it is because it is for them that the most widespread contraceptive methods are primarily intended (the pill, IUD). It is first and foremost in their bodies that they are called upon to use birth control methods and it is up to them in their overall individual being to accept them psychologically. It is therefore important to understand the context in which a woman lives, the cultural laws she is subject to, and the

other traditions and roles that govern her choices. In most cases, we are faced with a sociocultural reality dominated by an authority that is to all intents and purposes a male one; in such societies, the only inalienable power women are acknowledged as having is that of giving birth to children. Girls are raised as a function of their future role as wives and mothers and the way women acquire acknowledged social status is in accomplishing these functions.

As infants are their only wealth, the number of children they have becomes the capital of the poor; in a couple, pregnancy is an indication of the virility of the husband and a control over the sexuality of the wife; repeated pregnancy confirms the power of the man and enables him to ensure his spouse's fidelity.

Women, tied down to this physiological reality that carries with it social standing, have been obliged to confine themselves within this role and to derive from it the source of their self-esteem, their reason for existence in the world and their value as individuals. Thus it is that through repeated childbearing the wife gains love, respect and social standing.

This is where family planning comes into play.

When we seek to provide information on the possibility of contraception and the means for undertaking it, we enter into the above-mentioned situation, trying to introduce a change into codified rules and thereby upsetting the balance of roles between the partners. By freeing a woman from undesired childbearing, by showing her the advantages of birth control, we simultaneously remove from her the sole position of power that she previously occupied; what is given her in exchange?

One of the obstacles to successful contraception is, there is no doubt, to be found at this level; a woman loses some of her authority and becomes an object of mistrust for her husband and society; she is allowed to discover gratuitous sexuality unsanctioned by pregnancy and therefore becomes more free. Is she in a position to take up this liberty unaided? Or will she be obliged to sabotage the contraceptive method in order to enjoy the same consideration as before? How can she agree to see herself deprived of the faculty that has hitherto reinforced her value as a spouse and in society?

It seems important to avoid this stumbling block by proposing in the first place to the wife and secondly to the couple something in return that would support the decision to regulate births.

At the level of the couple, it may be thought that the idea of reciprocal sexual pleasure free from the fear of unwanted pregnancy, and therefore having only the pleasure of the partners in mind, would constitute a considerable step towards freedom and could take the place of the dimension referred to beforehand (this would pave the way for discussions that were more to do with sexology properly speaking, and it would be important to be ready to reply to new questions and increased and differing demands on the part of the couple).

But a new range of problems opens up to us if the immediate goals are reached. We have to ask ourselves whether we are capable of providing this *quid pro quo* with impunity or whether we run the risk of precipitating the woman into distrust on the part of her husband and society from the moment

her body no longer displays any sign that sexual taboos have been broken? How should this problem be tackled in order to prevent it from becoming an obstacle insurmountable to the success of contraception, a success which, as was said initially, we consider to be of crucial importance in giving women their dimension as individuals.

If we cannot answer this question, which is one that would be worth discussing at greater length, at least we can give our point of view, and that opens up a chapter that is of equal importance: the training of teachers of contraception.

To provide such teaching, it is at least essential to have adequate training, and also and in particular to have asked certain questions and found the answers so as not to be taken by surprise if some of them are also asked by contraceptive users. This openness of mind presupposes not that there is an absence of conflicts but that they have been resolved and above all that they are recognized as conflicts and coped with.

Women who use contraceptives and women "teachers" (as well as men, incidentally) are faced from the outset with the same types of psychological resistance and the same social constraints. It is essential for such resistance to have been detected, confronted, understood and overcome if the users are to be assisted by the teachers to become aware of the importance of family planning and to use contraceptive methods correctly.

Let us try to review the main types of resistance encountered in learning how to use contraceptives and to practise contraception successfully.

We should first of all refer to the mental image of family make-up which each of us possesses. For personal reasons bound up with the history of every individual, we all have an image within us of our ideal family size in which the number and sex of the children vary. If the idea of contraception succeeds in altering, even in part, this ideal image before it is realized, it will be bound to be considered as an obstacle to that realization and the risk of undermining or rejecting it will be all the greater. The image also comes into play among health workers made responsible for planning in that they will refer to their own ideal image when encouraging contraception or not.

The second obstacle is the one referred to earlier: the undermining of the woman's role at the social and marital level, and the consequent need to establish a new balance. By freeing the woman from unwanted childbearing, contraception in some respects opens up for her other possibilities and other qualities of life, giving her room to express desires, which both stimulate the need and at the same time make it feasible.

In addition, contraception opens up a way towards other types of satisfaction, whether the possibility of study, professional success or the simple discovery of other areas of interest. This would seem to be part of the progress of women in achieving their status as social beings. It does not merely represent a woman's right but also the enrichment of society; but how many people hold this opinion? And how many, on the other hand, will fear to intervene in the delicate balance of the position of each woman in relation to motherhood, not knowing or not being able to take on the task of establishing a new equilibrium that would certainly be richer and more responsible but assuredly give grounds for greater conflict?

At the marriage level, other factors arise that stem more from the sphere of relationships and emotions and therefore belong to the private world of the individual. Contraception alters the balance of the marriage by making the sexual role of the woman more important, in a way that is not "justified" by her function as a mother. Many women will feel impoverished if this function is missing because, on the one hand, it deprives them of the essential prerogative of authority they have, and is intrinsically a loss, while on the other hand, it forces them to face sexuality as an "end in itself". But to accept this "end in itself" means that the woman will have to comprehend sexuality as a function providing pleasure, and this is not necessarily something that goes without question when the cultural and moral norms prohibiting it are borne in mind.

Such norms can create a very heavy burden and even induce frigidity among women who were previously perfectly capable of enjoying satisfactory sexual relations. It is as if the woman was being offered access to sexual pleasure without being brought up to contemplate such a possibility; and this leads to anxiety at the prospect of a promised pleasure that she is not always equipped to face.

In addition, this increased sexuality in the female role may be perceived by the husband, who is just as ill-prepared as his wife to take it on, with mixed feelings in which the possible relief due to the ability to regulate births is accompanied by a certain distrust stemming from the danger his feeling of possession is now subjected to.

The couple then find themselves open to reactions of jealousy as a result of the woman's extra-marital freedom, which can certainly be real but are often imaginary. To this should be added fears of impotence arising from the elimination, however temporary, of the potential capacity to procreate; this phenomenon is much more frequent among men who confuse or more or less consciously identify sexual power with reproductive power and who fear the absence of external signs of the frequency of their sexual relations.

It is of particular importance to take account of this latter point, masculine resistance to contraception, as one of the most delicate and crucial issues in bringing effective contraception into being, because we cannot act as latter-day crusaders and combat the prejudices and obstacles faced by birth control and by free and responsible motherhood and fatherhood. Rather, we must be conscious of the role we are called upon to play while respecting the consciences and freedoms of the individual and the couple. Our task is to free such men and women from their fetters rather than to convince them to use methods that would clash with their views of the world and of marriage.

In order to do this, both individual effort and teamwork are essential on the part of the teachers, and that places them in a position to bring their own contradictions and prejudices out into the open and, thus enlightened in relation to themselves, makes them better able to listen to others without fear, prejudice or preconceived reactions.

Community diagnosis

T. Amat

The more we progress in analysing the results of interventions by health technicians, the more we perceive that the role must, if there is a desire to arrive at a reduction in high mortality and to improve the health level of the community as a whole, go beyond the purely therapeutic and extend to prevention.

The sphere of prevention is a very broad one, comprising all those individual and collective measures that make it possible on the one hand to improve the ability of the organism to protect itself from disease and on the other to act on the surrounding environment so as to preserve those aspects of it that favour health and modify those that can damage or diminish the health potential of each person.

Primary health care, the new health strategy proposed by WHO and adopted officially by many countries since 1978, stresses the need to integrate different types of preventive activity and argues forcibly for community participation in tackling health problems.

In this new context, the health technician is bound to be entrusted with therapeutic responsibilities, obviously, but will also have responsibilities in the sphere of prevention. He will often have to play the role of community organizer. He will have to assume a training role when working with health teams or communities.

But the change, of course, is scarcely an easy one. Old habits die hard, particularly where they concern the prestige that attaches to treatment and, let us recognize the fact, the low regard held for preventive and educational activities, except perhaps for vaccination programmes. Administrative infrastructures are also resistant to change: the compartmentalization of administrations, the excessively "greedy" budgets of the health care infrastructure, etc. do not make it easy to implement a different policy. Finally, in the background are to be found the health personnel training institutions that do not change, or do not change enough, in relation to the new responsibilities that health technicians should take on.

Health workers are continuing to be initiated into an understanding of disease. Cause and effect are properly studied along with the means available for treating sick individuals. Medical research has made enormous progress in this domain and it is the duty of health personnel to be capable of allowing patients to benefit from the fact.

All this training is improving day by day and it now constitutes a precise and detailed programme which is known to the teachers and involves the use of a wide variety of teaching approaches — manuals, guidelines for practical work, demonstration materials, etc.

How should change be introduced in this context and during the basic training of health personnel? Where can the time needed for acquiring the necessary knowledge and skills be found to arrive at a proper approach and to act effectively in the sphere of prevention, community participation and education for health, etc.? How can the teaching corps be expanded and a new approach to training, including perhaps a new distribution of academic

disciplines, be envisaged? How can a start be made without having available a whole range of teaching materials to ease the task of the teacher? How can a change in attitude among students be arrived at and how can a preventive approach be adopted that would result in a lasting improvement of the health of each individual, when the same change in attitude has not always been arrived at within the teaching corps and the health personnel already in position?

All of these questions, along with many others, will be referred to participants in the different working groups during the present conference. It is to be hoped that one and all will contribute to the setting up of training systems in line with the new needs.

The question we would like to tackle now is precisely that of the ability of the health worker to understand the people living in the area that he is assigned to.

Knowledge of the community

The ecological, economic, social, cultural and political context determines the living conditions of each individual within the community and the attitude of that community vis-à-vis other human groups.

In the course of time, each group develops a particular type of organization and a specific know-how, enabling it to profit more fully from the resources of the environment, to protect itself from harmful factors and to define the relations governing coexistence between individuals.

Each community more or less explicitly lives through a certain pattern of development. This pattern possesses a logic which shapes the attitudes of individuals who have a system for communicating the knowledge that is indispensable to all and sundry for achieving success in it and who always have a code aimed at lubricating the cogs in the machinery essential for its smooth functioning. The same community is bound to have lived through events (drought, colonization, war, emigration, etc.) that have thwarted this plan of development, obliging the group for a long or short period of time to seek readjustments in order to ensure its survival and to find ways to escape from "poor development".

Every health technician should endeavour to become familiar with the physical and human context of the community in which he has to work as well as the more relevant events in its historical background.

Another of his tasks will be to define the pattern of development that the group of humans in question is experiencing at present and the degree of control over that pattern possessed by the community. Are all members of the community taking part or only certain ones? Is such participation a function of their age, their sex or their economic power? Is the pattern of development an internal one, and part of that community, or has it been imposed from outside? To what extent does the present pattern of development, as experienced by the community, meet the basic needs of different members of that community? How do the members of the community voice their unmet needs?

This knowledge of the group, analysis of the factors that have influenced the life of its members, and awareness of the degree to which the basic needs of each are met, go to make up what may be termed *community diagnosis.*

If the aim is the improvement of the health status of families in the community, it will be essential to undertake an analysis of those factors that influence the health of the individual and the group and which go to make up the structural causes of the health level of each individual.

This very wide range of factors — physical, economic, demographic, social, cultural and political — may exercise a benign or harmful effect on the health of individuals and the group.

The relationship between such risk factors (or factors that harm health) and the means of eliminating or reducing them (benign factors) governs the state of health of each individual.

The balance between the factors often varies according to the age and sex of individuals in the community as well as according to profession, economic level, educational background, etc.

Analysis of the factors must take account of two parameters. On the one hand, the most objective identification possible must be made of risk factors for health and individual and collective techniques available for combating them. But it is also essential to consider the subjective expression of these factors voiced by members of the community.

For the most part, the relationship between the objective acts and the way in which subjective facts are voiced is a wide one, in which case it would be easy to accept priorities.

But if the area in common is narrow, a particular effort of communication, discussion, and exchange of information within the community will be required before it is possible to select a priority activity.

In cases where there is no area in common, this is an indication that there has been an incorrect analysis or interpretation of data collected or that the views expressed by the members of the community have been mistakenly put. After examining the circumstances which have led to such a situation, some work will need to be redone.

However, knowledge of the community is not solely the business of agents outside the community who work for the development of the area. If one accepts the principle that the development of a community should be the fruit of an internal dynamism, the essential element then becomes the analysis of the situation made by the community itself.

The intervention of outside persons can only be a secondary element and a technical support for the analysis, decisions and actions that the group will have to carry out. After an internal analysis (appraisal = diagnosis), the community (or individual) will be able to identify and express a number of unsatisfied needs in relation to the idea of happiness of this particular group.

The selection of priorities and the search for the most appropriate ways of meeting needs or resolving a problem will also be the result of joint work involving the community.

Thus, for the outside technical worker it is not a matter of making "his own diagnosis" or of determining, in his capacity as an expert, the needs

which seem to him to be "realistic" for the "obvious" priorities, or the "logical" ways of arriving at a solution of the problems identified. On the contrary, it is a question of listening to this group and of assisting it to analyse a given situation or to carry out an activity aimed at resolving a specific problem.

There are a few occasions when the outside agent will himself have to induce this analysis within the community. But in most cases, it has already been done and it is a simple matter of identifying it.

In brief, to succeed in initiating real community development, the notion of "doing something for" the community should be replaced by that of "doing something with it".

This does not mean that studies made by technicians to arrive at a better identification of problems are not of interest, but this is true only provided that they know how to pass on the results of their observations in such a manner that the community can digest the data and use them for better appraisal of the situation, better selection of priorities and better implementation of activities designed to achieve a solution.

This line of approach, by and large known as the participatory investigation technique, requires nevertheless that the development agent be convinced that members of the community have something to teach him and that the group possesses the resources and capacity for renewal.

Training of health workers in "community diagnosis"

In the past few years, "community diagnosis" has formed a training module in the WHO/ICC international courses on family health and family planning.

Implementation of a suitable family planning programme must be based on the most extensive possible knowledge of the factors influencing the health of individual families. For these reasons, it has been decided to devote part of the training period to this aspect of the matter.

The period of time set aside for the module is too short to be able to attempt to train participants in the techniques that facilitate knowledge of the community. The four days are however enough to familiarize them with certain methods such as consultation of registers, analysis of documents, interviews with community leaders and members, observation of the environment, management and analysis of a questionnaire, note-taking, etc. But the most interesting result of the module is motivation of participants to approach the problem and to exchange ideas with the community.

So far as the composition of the module is concerned, we have adopted the following programme.

First day

"Community diagnosis". What is it? Why? How?

— Introduction of the subject by the moderator, group work and joint development of coding sheets for analytical purposes.

Second and third days

Visits to different urban and rural communities in groups of five or six participants.

— The programming of activities during community practice is left to the initiative of each group, to a greater or lesser extent under the guidance of local health personnel.

— Almost all of the groups visit a health centre and talk to the staff. They also have discussions with the authorities and certain families, visit places of work and go to schools where they have discussions with teachers and pupils, participate in meetings, etc.

Fourth day
Collation of the information obtained and analysis of surveys. This operation makes it possible to:

— summarize the main factors having a positive or negative effect on the health of the family or community in the place under study;

— identify one or other of the risk factors with a great degree of precision;

— relate needs and priority goals to the needs and priorities voiced by different members of the community;

— understand those elements useful for programming and for carrying out family planning activities.

Subsequently, each group submits its findings to the participants in the course as a whole.

The last portion is devoted to methodological observations.

The small amount of time available and the complexity of practical organization have prevented part of this training module from being implemented. Insofar as reference is made to sending back data to each community that has received the groups, this is in the clear knowledge that it is a matter of an initial impression which will be developed with the input from each person concerned.

From the development standpoint, the technician must know how to convey the results of observations he makes in the field back to the community clearly, simply and in a suitable fashion.

It is important to give consideration to the way in which information is provided back to the community and to the usual information transmission methods within the latter. In groups in which oral transmission of information is of prime importance and a large proportion of individuals is unable to read or write, there is no point in trying to interest the group or make it understand a method which uses "scientific" tables and summary charts. In each case, it is essential to study the most suitable methods for transmitting information collected so as to allow the community to understand and to arouse discussion and exchange of views on the subjects raised.

Some comments on the above teaching module
Health personnel can be familiarized with the community quite quickly so long as the teaching is based on practice, i.e. on a real introduction to a community and the identification of priority health problems.

The role of the teacher will be to motivate and guide the working groups and to provide enough theoretical and practical tools to make it possible for each individual to make a "community diagnosis".

Preliminary contact must be made with the receiving community. It is essential for the latter to be informed of the usefulness of the work to be done by students and the methodology selected so that they can appreciate the interest that the practical work of the students may have both for the latter and for the community itself. It is essential for the community to be in a position to freely accept or reject the practical field work and to give its agreement to the group spending time there. It must be in a position to evaluate the interest of a given activity and to assist in improving the methods proposed by the teachers.

It is not a good idea to keep the same practical field work areas year after year because it will not be long before the community is tired of being so closely examined and questioned on the same subjects, while nothing is done to resolve their problems.

The attitude of teachers and students greatly influences the quality of exchanges between them and the community. The latter will be very quick to divine the underlying intentions of those who wish to "know". Are they striving for a better analysis of the problems in conjunction with them? Or simply to extract information? Are they setting in motion a dynamic analytical effort and striving to solve questions in common? Or is all that they are interested in a hasty judgement and the distribution of a few pieces of on-the-spot advice? Are they trying to understand in order to provide more valuable support to the community? Or to be in a better position to manipulate it?

The work involved in arriving at an understanding and knowledge of the community demands the support of other technicians than health workers. Analyses made by technicians with local responsibilities in agriculture, education, vocational and manual training, hydraulics, etc. will prove to be of great use for the health worker. But it is important for him also to become familiar with the statements made by other technicians.

A knowledge of the community is not a once and forever thing, acquired as soon as the health worker is in post. The community is a living tissue which acts and reacts to a number of different factors, now advancing and now retreating in order to prepare the ground for a new advance.

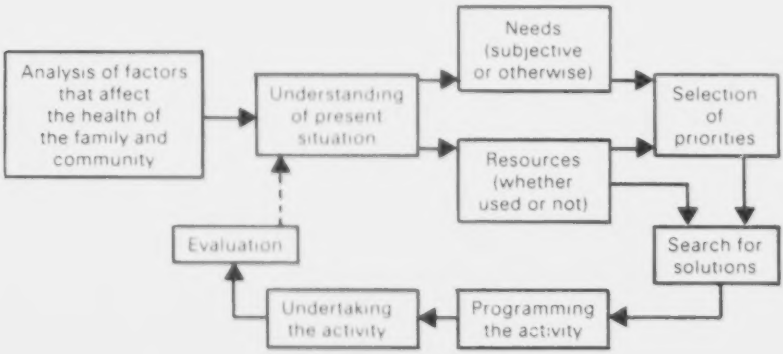
A knowledge of the environment must be an ongoing thing if such changes are to be recorded and understood.

The reason one speaks of introducing "indicators" is to give prominence to these changes. Conventional indicators should be backed by indicators that can be used for different actions underway and defined jointly with the community, which is the first to be interested in understanding the importance of the change.

Knowledge of the community and follow-up of trends in indicators are essential at local level in guiding the planning and action of the community and in determining the support provided by the local health worker. But at the same time, this knowledge is a very useful source of information for regional and even national organizers and planners, who often make very poor use of it. The reliability of information requires, however, that the

worker be motivated and have a desire to understand the community properly, that he be capable of collecting and recording information correctly and that he be encouraged in his work by his hierarchical superiors.

The understanding of the community obtained by harnessing the latter's dynamics should be extended by taking decisions and arranging priority activities designed to improve health.


Analysis of factors that affect the health of the family and community
Understanding of present situation
Needs (subjective or otherwise)
Resources (whether used or not)
Selection of priorities
Search for solutions
Programming the activity
Undertaking the activity
Evaluation

This approach causes no problems for health personnel already in post who are there in any case to help improve the health of each individual.

But so far as students are concerned, familiarization with the community should take place with the support and advice of health personnel already in position in such a way as to make possible a continuing exchange between the community and the health workers.

Conclusion

To become thoroughly familiar with the community must be a goal in the basic training of all health workers if it is desired that they should be of real use and help in improving the health status of each individual. This is not done very frequently, but in some institutions it is the practice.

It would be interesting for such training practices to be more widely known so as to encourage others to set up models suitable for acquiring the knowledge and skill necessary to understand community problems and to develop jointly with the community the strategies that might improve the situation.

Psychosocial and educational aspects of family planning

Ph. Lecorps

The psychosocial aspects of family planning may be defined as being all those disciplines and languages that view man both as an individual replete

with desires and contradictions and as a social being living in a society and culture that shape him and give a framework to his life.

One can go on to define the educative aspects of such planning as being all those communication and information techniques and social strategies that have to be put into effect if man, as part of his community, is to acquire the available information and techniques and thereby to develop his own plans.

The psychosocial aspects

But why speak of psychosocial aspects in the family planning sphere?

The practices that make up family planning must allow individuals and couples to attain certain personal goals:

— to promote desired births,

— to have an influence on the intervals between births,

— to avoid unwanted births,

— to determine the number of children desired to make up a family.

Each of these aims is linked with individual, cultural and political problem areas.

At the individual level, the question is to know how the partners view the child to be born, planned and desired, how the woman in particular experiences the desire for or the postponement of pregnancy, how she will be able to develop her love relationship in isolation from the risk of procreation and how the man when faced with this new, to some extent "free" woman, will be able to continue to keep his confidence.

These feelings experienced by men and women over family planning form part of a range of meanings, values and models laid down and strengthened by the cultural background. It is the environment which, at a given period of time, in a given locality and for a given social category, decides what is constituted by "good sexual behaviour", the respective roles of men and women, the rules governing the way they meet one another and family size.

The views of society concerning children to be brought into the world or avoided are taken up in each country by the national authorities which, using economic, demographic or health situation analyses, lay down natalist policies to combat the aging of populations or birth spacing policies to improve the health status of mothers and children or even policies designed to act as a brake on population pressure.

In the choice and effective use of medical or social techniques to promote birth, delayed birth, adoption or abortion, all those family, societal, and religious norms and the political options of a country play a part, which always has to be identified for the individual concerned.

One of the purposes of the training will be designed to permit health personnel to comprehend the different levels of argument on sexuality and birth with regard to their own lives, so as to improve the way they receive and listen to a person attending for consultation, and to match the technical solutions proposed to the needs of the community in question.

Educative aspects

It is interesting to note that training in planning is often designed only to provide practitioners and the public with information and techniques, as if these could be treated in isolation from the culture that has made possible their emergence and dissemination.

However, what is new in the history of mankind is not the effort by man to master fertility, an effort that has succeeded in many countries and has been tried everywhere else, but the appearance in the last 30 or so years of an entire range of contraceptive tools that are to a greater or lesser extent effective, harmless, agreeable to use, and acceptable to couples. What is also new is the existence and development of a collective discussion on man, woman and the way the two meet, on sex life and eroticism, and on sex life and procreation.

The foregoing is worth recalling here to show clearly that nothing that affects family planning can be treated in isolation from the social organization producing the tools and arguments that facilitate it or prohibit its use.

Let us note then that the effective use of family planning techniques is observed above all in the urbanized areas of industrial countries, i.e. in areas where at the same time changes in housing, working conditions, education, entry into a system governed by monetary relations and, more deeply still, a major change in consumption models, have been observed. The financial cost of the arrival of a child assumes its place as one of the constituents of a family development plan, competing with the purchase of a house, the financing of a car, and various types of investment related to children already born or family comfort.

In normal urban middle-class conversation, a new concept has developed, that of the "wanted child", a phrase that has gradually come, through a process of linguistic slippage and reduction of meaning, to have a meaning close to that of a "planned child" rationally desired and directly dependent on what the family economy permits, on the health of the mother and on the harmony existing in the life of the couple.

The educational messages are developed from this standpoint of the "wanted child", the child that is born as a result of conscious choice, and responsible fatherhood. We argue that such approaches are already suitable for reaching the middle classes in towns in industrialized countries and at any time now those in non-industrialized countries.

But we know that most men and women now alive and most of those to be born in the next few years will have their roots in rural surroundings and more particularly in the rural world of non-industrialized nations. In that environment, the organization of labour, beliefs and myths relating to the relationships between men and women, and the risks of infant mortality, demand that the woman constantly demonstrate her fertility: the child is the essential proof of the woman's affection and of male power. The large number of children is what guarantees the survival of the family farm.

Social techniques that allow the number of children to be matched to the needs of family self-reliance, such as the prohibition of sexual relationships at certain times or the giving away of excess children to members of the family who are better off nowadays functions only with partial success. Traditional

birth spacing techniques such as potions and amulets nowadays seem to be very ineffective.

At the same time, modern medical techniques do not appear very credible. For these groups, with the different thought patterns that govern their lives, it seems unthinkable that the paraphenalia of the family planning team can control a woman's fertility. They also consider it strange that in order to have children they should not have them and what is more, that they must pay for the privilege.

Finally, the techniques are often taught, disseminated, and provided by personnel (doctors, midwives, teachers and health educators) who differ so much in terms of their socioeconomic status, lifestyle and aspirations, that it seems difficult for the most poorly-off population groups to be able to appreciate the teaching as a life-giving message. Does it not seem more likely to be heavy pressure from the dominant class trying to indoctrinate the poor with methods of not reproducing?

Educational messages relating to family planning therefore make sense to and can be directly taken up by the middle class who compile and disseminate them. However, they must be radically changed if they are to penetrate the countryside and produce the beneficial effects that are to be expected from a reduction in population pressure on economic development, and from improvement in health of mothers and children already born by extending the interval between births. The change will have to be made by health and development workers taking into account all value systems that relate to the family, pregnancy, delivery, the number of children and rural health in general.

It should also not be forgotten that in graphics or visual aids, frontal or side-on cross-sections of the male and female genitalia mean something only for those individuals trained to understand such abstractions; for most rural populations that have little familiarity with such graphics, the representations are meaningless.

A major effort will therefore have to be made to bring practitioners to an understanding of what family planning means personally to those attending for consultation. The practitioner will then have to be able to explain, using his or her clients' own words and suitable imagery, how the male and female bodies function and how the different available methods of contraception operate.

With such training, health personnel will make it possible for the community in which they work *to focus attention on itself*, to define its own needs and to manage family planning side by side with maternal and child protection and development, in the realization of its own community projects.

Evaluation of family planning activities

E. Wollast

Any provision of knowledge and techniques aimed at making health personnel responsible for a given activity must always be backed by an introduction

to evaluation methods designed to check and improve a given activity. All health workers have a concern in the evaluation of their activities, irrespective of the level of the health system where they operate. Thus, in the basic training of physicians, midwives, nurses, etc., the programme should include simple evaluation procedures designed to meet the needs of their operational activities.

In addition, family planning activities by their very nature require more control and supervision than most health services. There are a number of reasons for this:

(*a*) they are services of the preventive type which go beyond supposed, albeit poorly expressed, needs of the population; thus it is a matter of ensuring that expectations are properly met;

(*b*) family planning often forms part of major programmes which make use of considerable financial resources and staff, and it is therefore of major importance to calculate the impact of the activity;

(*c*) the effectiveness of contraceptive methods is closely bound up with their continuity, and that presupposes specific evaluation methods.

Finally, and more generally, it is useful to recall that evaluation must always be conducted from the standpoint of change, with a view to improving services. To some extent, it ensures that the activities of health workers are tailored to meet the needs of the population. Teaching that is limited to the imparting of theoretical knowledge or familiarization with given tasks, without evaluation procedures, trains people to provide static services that rapidly lose their value.

The teaching of evaluation methods must make it possible for users to arrive at judgements as to their own work (or as to a point of departure) and to make changes to it with a view to improvement. A number of different types of evaluation must be tackled if future workers are to be able to respond to the various problems they will be faced with: problems related to their pattern of organization and performance, to the quality of care and to the efficiency and effectiveness of their programme. All these different types of evaluation must stem from the initiative of the workers themselves and be carried out by them. For that purpose, training must deal with the three phases essential to any evaluation process:

— selection and definition of subjects to be evaluated;

— evaluation procedures and tools suited for different subjects;

— organization of steps and procedures to ensure the success of evaluation.

More specifically, teaching of evaluation concepts in a family planning training course should cover the following points.

1. *Clear and coherent definition of the various goals of family planning:* demography, family health, risks to mothers, etc.

2. Demonstration of the relative importance of *the various types of evaluation* applicable to family planning activities; relevance of the programme, performance or quality of service, continuity, impact on the population, etc. For such teaching, it is most important of all to ensure the acquisition of the tools needed to carry out "internal evaluations" in a service (checking of performance and the quality of service), which by and large relate to operational activities.

3. Acquisition of *simple evaluation methods*. Initially, this means the computation and utilization of classifiers, and the selection of demographic and family health indicators, and of criteria related to what it is intended to measure. The making of simple measurements (relationships, rates, percentages, etc.) and the use of norms making it possible to interpret the results are additional elements in acquiring such knowledge.

4. Determination of *procedures requiring evaluation*. Here, training must teach the student to specify clearly what is being investigated (what decisions the evaluation is designed to back up) and to arrange data collection (establishment of a "family planning" heading in a file, for example). It is also useful to determine the most effective procedure for obtaining important results such as continuity, e.g. through continuous evaluation or periodic survey.

Finally, it would be necessary to provide students with an ability to define *intermediate indicators* enabling them to appreciate the impact of their activity in the short term and its more direct or less direct relationship with their programme. Intermediate indicators lie between the end goals and the means undertaken. In family planning programmes, a good intermediate indicator could, for instance, be the gap between births, which is much more sensitive to family planning activities than the birth rate.

Pedagogical support to family planning programmes

M.A.C. Dowling

Specific teaching and learning methods and materials need to be developed to meet the needs of the different categories of individual involved in family planning activities. Each type of learning or user requires different materials and different approaches. The categories are as follows.

1. *Practising physicians*. This group requires recent, frequently updated materials. The use of microfiches, wall charts or illustrated brochures, with accompanying texts and/or cassette tapes, could be considered for this purpose. One example we might quote is the continuing education programme of the American College of Physicians.

2. *Medical students.* For this category, teaching material and methods need to be developed which can easily be fitted into an already heavily loaded programme of work. Teaching and learning methods will be backed by suitable techniques such as case studies and self-instructional units. The teachers would require slides, films and/or video cassettes, which illustrate especially the demographic and psychosocial aspects of family planning. Medical schools could take the initiative by developing materials for use in teaching at all levels. Most schools have very active departments of medical illustration which could undertake the task of preparing sets of slides or other audiovisual materials. This procedure would have the advantage that, unlike most commercially available products, materials would be directly relevant to local situations.

3. *Trainers of family planning workers.* Materials similar to those mentioned in paragraph 2 above may be used, although the curricula will, of course, be different. Role-playing is an excellent method of learning. Case studies are also very important as a basis for discussion groups. They should be based on specific factual information, preferably relevant to the local situation. This demands an effort, on the part of trainers and supervisors, to collect data on typical problems facing family planning staff in the field. Such problems, properly illustrated, will form an excellent source of teaching material which can be used in many different ways by teachers at all levels.

4. *Family planning workers.* This category of staff will require reference guides on different contraceptive methods, checklists for use in consultations or discussions with "clients", a variety of simple audiovisual material for demonstrations (flip charts, flash cards, posters and models). Practice in the use of materials in simulated situations should be built into the training so that the students become familiar with them. The case studies referred to above (paragraph 3) can be adapted for these simulations. A problem common to all staff in the field is that of updating and refresher training so as to maintain and constantly improve the quality of their performance. Considerable experience has been gained in the use of "distance education" in developing countries over the past few years, making use of radio and correspondence. The potential provided by this method could be borne in mind for the continuing education of field staff.

5. *"Clients" and the general public, including schoolchildren.* Here, we should select examples from the wide variety of available materials, brochures, films, non-verbal materials, short radio and television programmes, etc. It cannot be too strongly emphasized that all such material must be field tested with target audiences before release and dissemination. Additional methods of communication such as the "photo novella" (in Mexico), puppet shows, songs and stories should also be used, particularly in developing countries.

The following works may also be consulted.

Abbat, F.R. *Teaching for better learning: a guide for teachers of primary health care staff.* Geneva, World Health Organization, 1980.

Guilbert, J.J. *Educational handbook for health personnel* (revised edition). Geneva, World Health Organization, 1981 (WHO Offset Publication No. 35).

Holmberg, B. *Status and trends of distance education.* London, Kogan Page, 1981.

Young, M. et al. *Distance teaching for the Third World.* London, Routledge & Kegan Paul, 1980.

3

Activities of study groups: some reflections on training in family planning

K. Edström

Training in family planning has recently undergone a radical change. Nowadays there is greater realization that training programmes must be directed towards community needs. The specific tasks of health personnel in training matters must therefore be defined in relation to these fundamental needs.

It is intended to set forth here certain basic principles that can be applied in the training of both medical personnel and the traditional birth attendant.

1. A start must be made by defining community and individual needs and translating these into health care activities and tasks.

2. Care must be taken to ensure that training of one category of health personnel is not made in isolation from training programmes for other professionals. Decisions on responsibilities within the team must be taken on a joint basis. Moreover, in the primary health care approach the team consists of several persons, including workers from other sectors. Moreover the key person in the team is the "client", i.e. the individual or couple requiring information on the prospects open to them in planning their family.

3. Finally, training must be founded on a detailed knowledge of what the students will have to do, on what their resources are, and in what conditions the tasks must be carried out. The basics for drawing up a training programme consist in: a definition of educational goals, the development of a course structure (curriculum), the selection of methods and teaching materials, and an evaluation of the programme results.

In recent years the Family Health Division at WHO has been promoting task analysis studies to obtain better results from maternal and child health and family training programmes.

The report[a] on a consultation held in Geneva from 13 to 16 August 1979 on systematic approaches to task analysis in maternal and child health care,

[a] Unpublished WHO document, MCH/HMD/79.1, 1979.

lists the steps to be followed if programmes for training or planning of services are to be relevant to the needs of a population. This approach applies equally to the training of health workers, to the programming of maternal and child health/family planning services and to the development of a primary health care team.

In analysing what a health worker has to do it is not sufficient just to focus on the technical matters (for example, the use of a given contraceptive); one also has to consider the person herself, her problems, her information needs in relation to available methods and health services, etc. As an analysis this is not something that is self-evident. It is even essential if an effective training programme is to be prepared. The curriculum must be based on an analysis of problems experienced by individuals and groups. Because of the tasks of the health worker emphasis is placed on practical training methods. This does not mean, however, that other forms of training (seminars, for example) do not have a place of their own. But a conference on reproductive physiology is perhaps not the best method for use in a family planning training course; the most important thing is to present specific cases or simulations. This would make it possible to align the training process with the work to be done by the students afterwards.

Have the teaching specialists been adequately informed about evaluation methods? This may be doubted as generally speaking evaluation is limited to oral examinations, the use of a multiple-choice questionnaire and the setting of theoretical problems.

It is not enough for the student to be able to describe a procedure (e.g. insertion of an IUD). It must be ascertained whether she is capable of applying her knowledge in practice. Clearly, simple and precise measurement tools are required to evaluate a student's performance by means of observation.

Definition of functions of different professional groups in family planning

The participants were assigned to five study groups which then allocated responsibility for the various functions, as listed in Table 9, to selected professional groups such as: medical specialists, general practitioners, midwives, nurses, medical workers, social workers, teachers, etc.

The aim of this exercise was for the study groups to experiment with the process of drawing up curriculum design, the first phase of which consists in defining functions and allocating them among the members of the different professions concerned.

The work of the study groups was very worthwhile. The main problem lay in the fact that a single table of functions was proposed to all the participants, whereas each member of the groups had experience of very different situations in the home country. At the same time, the proposed model was slanted towards the medical professions and did not mention certain very important functions such as the need to identify the social context of those requiring services, the values they were expressing, their choices, desires, etc. As a result, in the exercise the tasks were in most cases

Table 9. Family planning

Action	Tasks	Category of personnel			
Activities designed to promote family planning	Motivation of community leaders, etc. Individual tracing Group information				
Counselling services	Information, including possible side effects of the methods proposed Choice of method Sex education				
Identification of families exposed to risks	Tracing, opening of files				
Initial provision of a contraceptive method (on contact, for family planning services) (determination of lactation, breast-feeding)	Oral contraceptives Injectible contraceptives IUD Vasectomy Uterine tube ligation Other inert methods (male contraceptives, periodic abstinence, etc.)				
Monitored distribution of contraceptive methods	Oral contraceptives Injectible contraceptives Other inert methods				
Treatment of complications	Treatment of minor side effects Administration of iron supplements IUD withdrawal Measures in event of failure of method				
Treatment of infertility	Tracing Search for previous instances, counselling Clinical examination Treatment				

allocated to health personnel, specialist physicians, general practitioners, nurses and midwives. The discussions showed that there was room for expanding the role of auxiliaries, social workers and teachers in the very wide field of the not specifically medical aspects of family planning.

Proposals for teaching family planning to different categories of health personnel on the basis of the defined functions

The aim of the exercise was not to give an exhaustive description of a programme that could be applied in all countries and to each category of staff, but rather to assist educational planners to develop or to revise curricula.

Each study group therefore endeavoured:

- to outline the general objectives for the teaching of family planning to the professional category under consideration;
- to make recommendations in respect of the necessary aptitudes, knowledge, attitudes, teaching/learning methods, evaluation techniques and means of integrating the teaching in programmes;
- to indicate ways of evaluating training programmes in family planning.

Basic and refresher training for midwives and nurses

Family planning must be integrated within the primary health care system. At this level nurses and midwives have important functions and should therefore receive specific training in family planning.

(*a*) *Basic training*

General goals

Upon completion of their training, the nurses must be able to:

- create an awareness in the community of the advantages of family planning;
- identify families or individuals that are in particular need of family planning and persuade them to practise it;
- take into account the psychosocial aspects of the various family planning activities;
- advise on a contraceptive method;
- identify and guide couples with an infertility problem, identify the main causes of infertility, and know how to prevent them;
- motivate community leaders and encourage them to take part in the activities;
- supervise traditional midwives and other community health workers in countries where such practitioners exist.

Knowledge	*Aptitudes*	*Attitudes*
General structure and function of a community main health or related problems	Communication with individuals or groups and with community leaders	Tolerant and/or positive attitude to family planning
What is family planning?	Supervision of traditional midwives and other community health workers	Understanding and tolerance of cultural and traditional patterns in the society
Factors influencing family and individual health, birth spacing, socioeconomic and biological factors, etc.		
Risk factors showing individuals and families at risk		Harmonious balance between personal choice and authority in relations with families and individuals
How to encounter and establish contact with clients, groups and the community		
Human relations and sexual behaviour		An understanding attitude towards different patterns of sexual behaviour
Contraceptive methods, side effects and complications		
Usual causes of infertility and methods of preventing it		
Legislative aspects of family planning, including abortion		

Teaching/learning methods

Communication techniques: role-playing, conversational techniques, lectures, use of audiovisual aids

Training in relationships: group discussions, role-playing, video recording and other audiovisual methods

Technical knowledge: case studies, problem-solving, lectures, handbooks and manuals, seminars

(*b*) *Refresher/further training*

Goals
In addition to the goals already mentioned in relation to basic training, general nurses should also be capable of:

- selecting methods that are tailored to meet the needs of their clients;
- assisting clients to make a choice and providing them with the most suitable method or referring them to a higher level;
- understanding and accepting the role and function of each team member with regard to family planning;
- collecting, processing and making use of the necessary data for a family planning programme;
- supervising family planning activities in the community;
- educating and guiding other health workers.

Knowledge	*Aptitudes*	*Attitudes*
Indications and contraindications for the different methods available	Clinical examination of clients	Ability to work in a team
Factors involved in the acceptance of methods at community and individual level	Description and provision of suitable contraceptive methods	
Legal, psychosocial and medical aspects of abortion	Diagnosis and treatment of complications	
Organization of monitoring of contraceptive users	Collection, processing and evaluation of basic data	
Approaches to infertility problems		
Role, function, rights and duties of different members of the team		

Basic training of medical students, further training of general practitioners and specialists

At the pre-university or secondary level, instructions should be given on:

biology,

population matters,

human reproduction,

human relations,

awareness of community needs.

(*a*) *Basic training of medical students*

Human reproduction and human relations

The students should acquire a basic knowledge of human reproduction and human relations geared to community needs and integrated with instruction on: anatomy, physiology, sociology and psychology; human sexuality; basic principles of family planning.

Family planning

Knowledge

As part of the social and community medicine course:

- population size
- age pyramid
- civil registration statistics
- fertility behaviour
- family health
- influence of environmental factors on health
- importance of family planning
- population dynamics

Knowledge

As part of the gynaecology course:

- review of knowledge of human reproduction
- contraceptive and pregnancy termination methods
- sterilization methods
- genetic counselling
- diagnosis, treatment and approaches to infertility problems
- human sexuality at different ages
- sexual minorities
- sexual dysfunction
- genital infections and their consequences

Aptitudes

Instruction in techniques of:

- clinical history and presentation of cases
- general examinations including breast examinations
- vaginal smears
- vaginal touch
- insertion of speculum

As far as possible, practical training in:

- different contraceptive methods
- prescription of oral contraceptives
- measurements for selection of diaphragms
- IUD insertions
- pregnancy terminations
- individual surveillance

Attitudes

Empathy:

- to be able to listen
- to respect the client's situation
- to be aware of her own values
- to give enough time for the client to feel at ease

Respect for human rights and the dignity of the client in the process of decision-making with regard to family planning

Other common subjects

In psychiatry:

- problems in human relations
- problems in the sexual sphere
- abnormal human behaviour
- mother–child relations
- family relations

In paediatrics:

- intra-family relations
- parental bonds
- relationships of the couple

The other medical disciplines should give attention to aspects of human sexuality, human relationships and family planning in relation to various medical problems such as: the effects of drugs, neurological conditions (paraplegia, etc.), surgical conditions and cardiac disorders.

(*b*) *Training of general practitioners*

Updating of knowledge on technical progress and the use of resources

Attitudes

As under (*a*)

Aptitudes

Strengthening of basic aptitudes:

case history

gynaecological examination

technical competence: IUD insertion and surveillance, interruption of pregancy

If necessary:

tubal sterilization by minilaparotomy

vasectomy

Approaches to infertility problems:

case history and genital examination

case study

advice and techniques of coitus, etc.

(*c*) *Training of specialists in gynaecology and obstetrics*

Knowledge

All aspects of fertility regulation (updating and extension of knowledge of infertility, contraception, abortion, reversibility of sterilization, tubal surgery, etc.)

Psychosexual problems

Elements of demography

Principles of genetic counselling

Guidance before conception

Health services concerned in family planning

Teaching methods

Inclusion of different aspects of family planning in the study of gynaecological conditions and the organization of care: antenatal, intrapartum, postnatal

Aptitudes

Contraceptive techniques, including sterilization and termination of pregnancy

Specific training in all the different methods

Advice on problems of fertility regulation

Advice on psychosexual problems

Advice before contraception

Organization of health services for the development of family planning activities as related to other clinical needs

(*d*) *Training of other specialists*

Paediatrician

Mother-and-child relationship

Sexual development

Sexuality of the adolescent and problems of fertility

Psychiatrist

Advice on problems of relationships and sexuality

Geneticist

Genetic counselling

Training of community health workers

With regard to the training of traditional birth attendants and home visitors, the question arises of whether the use of such personnel is for want of a better alternative or rather, on the contrary, is in accordance with the approach recommended by the International Conference on Primary Health Care (Alma-Ata, 1978), and represents an important means of making health less "technological" and placing responsibility for health problems with the community itself.

Functions

Analysis of the functions of this category of staff leads to the question of how far one can go in delegating responsibility.

The following functions were decided on:

- promotion of family planning: information, motivation and education;
- information of other health workers with regard to community needs and hence identification of such needs;
- individual case detection;
- provision of family planning services, prescription of simple and traditional methods;
- preparation of and participation in care;
- follow-up and "re-motivation" of cases;
- management of contraceptive stocks;
- participation in the collection of basic health and demographic data;
- guidance in cases of infertility.

Training

Principles. There is a need for a universally applicable training programme, but one suited to the local context; training within the integrated framework of family health; field training in the same conditions as those of professional practice; and short courses in the form of on-the-spot seminars.

Problems. Account should be taken of the fact that the training may have to be given to illiterates and elderly persons — hence the importance of suitable teaching methods.

Conclusion. Emphasis was placed on the important role of this category of worker, which should be seen as an entity. They are "intermediate personnel" responsible for care of minor cases and guidance of more serious cases. Their training should be brief as far as technical knowledge is concerned but more developed in terms of information.

Training of auxiliary health personnel

This term should be taken as referring to "rural birth attendants" with schooling up to the age of about 14 years.

Choice of candidates

The youth of the candidates makes their selection difficult. A number of criteria were proposed whereby preference would be given to candidates who:

- are open-minded;
- show adaptability;
- have a certain degree of independence in relation to their cultural and religious surroundings;

— come from and are members of the community but are also capable of standing to some extent outside that community.

Training
Such training should last a year and develop both attitudes and skills. With regard to *attitudes*, the training must ensure that the staff:

— consider women as a whole, give prominence to the personal views of the woman in relation to family planning and only then take into account the community and social aspects;

— as part of an approach that takes the psychosocial dimension into account, attach importance to listening to clients (in terms of what they express both explicitly and implicitly), and to their outward attitudes (happiness, sadness, etc.); develop empathy vis-à-vis the client (make her relax, smile, give encouragement); identify the resources and assistance available in the community, as well as the prevailing beliefs, cultural values and taboos; and analyse their own values and maintain a certain detachment from their own views;

— as part of health education for family planning, know how to listen to clients through dialogue that produces replies to problems raised; and develop an aptitude for teamwork.

With regard to *skills*, two examples may be given. One relates to the use of the IUD and the other to ways of enlisting the support of local community leaders.

— *IUD.* Staff must be familiar with indications and contraindications; selection of a suitable type of IUD; identification of psychological sources of opposition (foreign body, discharges, embarrassment, etc.) or religious obstacles (sin, etc.); performance of speculum examinations, follow-up of side effects, diagnosis and treatment of complications, insertion and withdrawal; and referral of the patient to a specialist if necessary.

— *Motivation of local community leaders.* In order to motivate community leaders it is essential to be able to identify them and find ways of convincing them, to be able to listen to problems, to put forward health arguments that will be accepted by the community, and to find and use the necessary means of support.

Training of social workers

Functions
Social workers have roles which are complementary to those of other health personnel. They seek to modify the situation by:

contacts with community leaders,

activities in the family (home visits),

information sessions for parents,

contacts with employers,

contacts with neighbourhood committees,

contacts with private agencies (for the handicapped, migrants, etc.).

Their goal is to appraise, inform, motivate, guide and reassure, and to assure the replenishment of supplies of contraceptives and monitor their use.

Training

Certain aspects of family planning could be introduced into existing curricula, namely:

listening and conversation techniques in family planning,

social, economic and medical consequences of family planning,

problems of communication,

laws, programmes and services relating to family planning,

knowledge of anatomy, the physiology of human reproduction, contraceptive methods, side effects, complications,

in psychology, the study of circumstances in which there is acceptance or rejection of family planning and psychosomatic symptoms,

an understanding of the behaviour of minorities.

On completion of their training, social workers must be capable of evaluating the family planning needs of an individual, a group or a community, assisting clients to select a contraceptive method by listening to them and giving them adequate information, refuting rumours that are damaging to family planning, and ensuring short- and long-term follow-up in cooperation with the health services.

The methods used are those of theoretical and practical training (in-service in family planning centres), with prominence being given to active involvement of students (role-playing, psychodrama, Balint groups, case studies).

Knowledge should be evaluated by examination, as for other subjects. Changes in behaviour among social workers can be evaluated by reviewing their reports on their practical training, which should give attention to family planning problems.

Strategies for application of the foregoing proposals to curricula

Because the conference participants came from many countries, it was not possible for the various subcommittees to make a detailed examination of national constraints and thus to propose specific strategies for particular country situations.

On the other hand, this forum provided an opportunity to give broad consideration to the constraints and obstacles that arise in redesigning

curricula for different types of profession and to propose strategies for overcoming them. What the subcommittees did was first of all to take note of the general obstacles associated with all family planning problems, including those relating to curriculum changes. This broad approach appeared to be necessary in view of the fact that the direction taken by the training is by and large influenced by political and cultural restraints, patterns of medical administration, the attitude of the medical professions, the availability of suitable teaching methods, and problems of teaching on sexual matters.

Obstacles to changes in curricula

Obstacles associated with policies
National policies that limit or prohibit family planning

Inadequate political will in relation to family planning programmes and training needs

Inadequate budgets for family planning

Inadequate resources for training: too little time and too few teachers for a large number of students

General lack of economic and teaching resources

Obstacles associated with culture
Images projected by the various religions and, more broadly speaking, cultures concerning the family and values attached to reproduction and fertility that may be very traditional and conservative and form serious obstacles to the design and implementation of family planning programmes

The role of parents' associations that often adopt traditional values and prevent the development of sex education curricula that would be suitable for schools

Obstacles associated with medical administration
The prevalence of conservative attitudes among medical faculties with regard to the attention to be paid to community needs

The fact that faculties are mainly concerned with clinical practice, and primary health care is not considered as real priority

Medical teaching that is centred on pathology and provides no preparation for understanding the psychosocial aspects of sexual behaviour and the life of couples

Preventive activities that are not immediately rewarding for health workers since the results are not direct, as in the case of treatment activities

The fact that family planning is considered as being a subordinate branch of medicine, to which little time is devoted

Teaching that focuses on the acquisition of knowledge rather than skills or attitudes

Obstacles associated with the attitude of teachers
The inappropriate attitude of medical and paramedical personnel in charge of supervision and the lack of professional prestige for family planning

Partly as a result of ignorance and partly for psychosocial and psychocultural reasons, the often negative attitude of teachers, which means that they are not ready to identify with the role that they should be playing

Lack of the necessary preparation for teaching family planning and true awareness of community needs in this area on the part of teachers

Inadequate knowledge of teachers concerning the most suitable methods for teaching family planning

Obstacles associated with teaching
Lack of teachers with an adequate background for implementing programmes

Lack of real coordination between theoretical teaching and field practice

Teaching materials that are often ill-adapted to instruction on family planning teaching

Inadequacy of continuing education for teachers

Curricula for basic training that are recognized as not being suitable, but are already overloaded and difficult to alter

Examinations that allow the evaluation of students' knowledge but not their ability to understand or solve problems relating to the community

Obstacles associated with teaching on sexual life
Difficulty of teachers in establishing true communication with young students with regard to sexual matters and family planning, i.e. not knowing how to establish it or not wanting to, which has something to do with their own situation and their personal problems

Relative inability of health personnel to deal with matters relating to the intimate lives of their clients, to desires and to pleasure

Where sex is concerned, the fact that teachers are faced with complex human factors and not merely with technical considerations

Strategies that could be used to change curricula

Strategies associated with policies
Through international cooperation, analyse training and organizational experience in equivalent departments in other countries

Improve the understanding of economic, psychological and social aspects of population problems

Improve relations with political leaders to bring laws into line with social practices

Assist in giving effect to family policies that include family planning

Identify "friends" among gynaecologists and paediatricians at national level who are in a position to discuss matters with national health decision-makers

Conduct pilot actions with a view to evaluating constraints and resources and to expanding the scope of activities

Take part in direct action with the community and local leaders

Strategies associated with culture
Provide religious leaders with complete and regular information and obtain their understanding

Initiate discussions on the attitudes of religions to family planning

Strategies associated with community information
Promote the dissemination of information to both the male and the female population

Disseminate the family planning message by every possible channel

Undertake information activities aimed at public opinion, pressure groups, decision-makers and training institutions, at both local and national level, so as to promote awareness of community needs in family planning and the advantages of family planning

Disseminate the information through the mass media, other audiovisual techniques, seminars, workshops, etc.

Strategies directly associated with training of health personnel

(*a*) *Teacher training*
Establish continuation programmes, including interdisciplinary refresher courses, for future teachers

Assemble a multidisciplinary team of trainers consisting of health workers in the field

Arrange for teachers, during their period of training, to get to know the community and its needs through practical field work, thereby developing their community work skills

Ensure that the teaching of family planning is free from specialization, i.e. that it is presented as part of training in basic health care integrated with community medicine as a whole

Ensure that teachers learn to go beyond matters relating to techniques and to train personnel in reception, listening and responsive behaviour

Make teachers aware of the need to understand specific problems and factors related to adolescents and their sexuality, so as to improve dialogue with them

Train teachers in problem-oriented and problem-solving teaching methods, and emphasize teaching–learning methods making it possible to acquire practical aptitudes

(*b*) *Organization of teaching*

Draw up curriculum content concerned with family planning in such a fashion that the student can identify and meet community needs while taking account of sociocultural and economic factors

Integrate the teaching of family planning and family health with various disciplines, one of which must be made responsible for its coordination in every aspect

Set aside sufficient time and provide the right logistic support to make it possible for students, during the training period, to come into contact with the community and identify its needs, as well as participating in health activities in the field

Ensure that the number of students for each teacher is limited so as to make it possible to provide quality education centred on a change in behaviour

Ensure that the evaluation of education is primarily concerned with assessing the ability of students to perform tasks specifically related to health and family planning

4

Presentation and discussion of a draft educational handbook

An editorial committee[a] met on a number of occasions to outline the general concept of an educational handbook and draft the section concerned with training in the health professional/client relationship.

The committee informed the conference of the reasons for drafting the handbook, its expectations with regard to the final content and the stage of preparation it had reached.

Reasons for an educational handbook

The teaching of family planning presents teachers with problems relating to:

- the non-availability or the lack of updated information;
- the difficulty of defining educational objectives in behavioural terms;
- the difficulty of introducing teaching methods in line with the goals that are aimed at.

What is being proposed, therefore, is an educational handbook providing a wealth of documentation that may be updated and adapted to different cultures and levels of personnel. The idea is to set out certain educational goals and a selection of teaching methods. This means that the teacher will have available a variety of raw materials which he can use in order to develop his own programme in line with his own goals and the group to be trained.

[a] This committee consisted of Miss W. Haddad, Regional Officer for Family Planning, WHO Regional Office for Europe; Miss M. Ladjali, Maternal and Child Health Central Office, National Institute of Public Health, Algiers; Professor P. Lecorps, Department of Health Education and Family Planning, National School of Public Health, Rennes; Dr M. Péchevis, Department of Training, International Children's Centre; and Mrs E. Wollast, School of Public Health, Free University of Brussels. The draft educational handbook was circulated to conference participants as document ICP/MCH 025/15. This document may be obtained on request from the WHO Regional Office for Europe.

The final content of the handbook

Family planning deals with numerous aspects of human life and presupposes cooperation by a variety of technicians and the application of a wide range of resources in order to satisfy demand expressed by individuals and couples.

The various questions involved in family planning training may be grouped under four headings:

- *psychosocial aspects:* i.e. all disciplines which consider the human being as an individual, with his desires and conflicts, and the human being as a part of a group within the community and culture that have moulded him;
- *organizational aspects:* i.e. matters relating to the management of institutions and staff providing for the expression and treatment of client demand;
- *biophysical aspects:* i.e. everything relating to the biological and physical mechanisms bound up with human reproduction and sexuality;
- *technical aspects:* i.e. the various methods and means available to help clients succeed in their family composition plans, as well as the various clinical interventions and observations which will help in arriving at an evaluation, and in suggesting prescriptions that take the health of clients into consideration.

The present state of the handbook

The handbook, as it was presented to the conference, contained the objectives, examples of methods to achieve them, and documentation for one of the topics of the teaching package on psychosocial aspects.

The topic is the health professional/client relationship in family planning. It was decided to draft this topic first because it is often neglected in family planning training, while success in family planning training programmes depends on a constructive relationship between health personnel and family planning clients.

It was considered as a working document, circulated as such for discussion and designed to be reworked and expanded in the light of comments made at the conference.

Draft teaching package on psychosocial aspects: the health professional/client relationship

Objectives

At the end of the training session the student must be able to:

- establish suitable conditions for an interview;

— identify the client's implicit or explicit request;

— meet the client's demand;

— assist in individual and community health education;

— evaluate the client's satisfaction.

Subobjectives

Establish suitable conditions for an interview

1. Create the physical and psychological ambience that will facilitate the client's first contact with health personnel.

2. Create the physical and psychological ambience that will give initial impetus to the interview.

Identify the client's implicit or explicit request

3. Express his/her own system of values as to social models, family organization, sexuality, contraception, abortion.

4. Identify the client's system of values as revealed by the interview.

5. Identify the client's request and re-state it.

Meet the client's demand

6. Define his/her own attitude to the client's request.

7. Present in language easily understood by the client an answer that takes due account of the client's request.

Assist in individual and community health education

8. Determine the client's level of knowledge.

9. Provide information, based on the client's or group's request, on the difficulties connected with sexuality and human reproduction.

10. Check the level of understanding of the information given.

11. State the advantages of family planning for better health and adapt them to the social groups concerned.

12. Select teaching methods suitable for the group.

13. Select useful teaching aids.

Evaluate the client's satisfaction

14. Draw up indicators for: the quality of the first contact with health personnel; the relevance of the response to the client's request; the degree of understanding of information received.

15. Use the indicators to assess client satisfaction.

The psychosocial aspects of medical examinations and prescribing will be discussed in the teaching package on technical aspects.

Examples of methods and means in relation to goals

Objectives	Topics	Methods and resources	Duration	Remarks
1 and 2	Conditions for first contact and effective initial interviewing	*Lecture* (followed by discussions) — 1 teacher	1–2 hours	
		or		
		Role playing — 1 organizer for a maximum of 12 people	1½ hours	Organize an initial contact interview Experiment with ways of initiating health personnel/client dialogue
		or		
		Video recording + group discussion — 1 organizer — 1 technician — camera — video-tape recorder — tapes	1½ hours	Video-recording of some contact scenes and the opening of the interview
		or		
		Clinical observation + report and discussion — 1 organizer — clinics and centres	to be established later	
3	Interviewers' recognition of their own system of values	*Seminar* — 1 organizer for a group of 15 people	1½ hours	Topic discussed specifically, while forming part of overall training package
4 and 5	Recognize the client's system of values and identify the demand	*Role playing* — 1 organizer for a group of 15 people	1½ hours	Simulate a given contact situation (spontaneous or prepared interview)
		or		
		Case study with video tape recorder — 1 organizer for a group of 30 people — camera — video-tape recorder — tapes		Taped sequence of portion of an interview showing only the client's request, to be formulated by the group

Objectives	Topics	Methods and resources	Duration	Remarks
6 and 7	Interviewers' attitude to the client's request Response to the request	*Role-playing* — 1 organizer for a group of 15 people or *Case study with video-tape recorder* — 1 organizer for a group of 30 people — camera — video-tape recorder — tapes		
8	Assessment of information given to			
	an individual and	*Role-playing* (interview) — 1 organizer for a group of 15 people	1½ hours	Establish what the client knows and how he/she uses it
	a group	*Role-playing* — 1 organizer for a group of 30 people	1½ hours	Establish a knowledge threshold applicable to the whole group
9 and 10	Provide information on sexuality and human reproduction Check understanding of the information given	*Role-playing* (as in Objective 8)	1½ hours	The student must prepare and use teaching methods with an individual or a group The student must ask the individual or group questions to verify understanding
11	State the advantages of family planning in a fashion appropriate to the audience	*Seminar* — 1 organizer for a group of 30 people	1½ hours	Students must use arguments suitable for the sociocultural background of clients
12	Choose suitable methods	*Lecture* + discussion — 1 teacher	1½ hours	Introduce criteria by which choices may be made according to — objectives — group characteristics — available resources
13	Choose suitable teaching aids	*Demonstration and analysis* — 1 teacher + available material	1½ hours	Justify the choice of teaching aids in a given situation
14 and 15	Evaluation through satisfaction indicators	*Introductory statement* or selected reading + Seminar with exercises	1½ hours	Allow the students to discover simple indicators (i.e. case histories, questionnaires) and teach them to use them for self-evaluation

Examples of role-playing

Consultation

Role of the "client". Your name is Mrs Lucie Demanet. You are 32 years old and you married at the age of 22. You have two children, Elise 8 years old and Jean 6 years old. Your husband is a policeman. You have completed the first few years of a secondary school. You don't work outside the home. You are satisfied with your married life. You have always tended to be overweight. Taking oral contraceptives has not caused you to gain weight unduly, but you wonder if it doesn't increase the tendency. You tried to lose weight, but you lack the discipline to forego the pleasure of a good meal. You are quite touchy on the subject, and you don't like it being referred to in particular because you once consulted a doctor about it, but you felt that he exaggerated the problem and made you feel guilty, and you never went back. Anyway, you do not intend to bring up this matter yourself, but if the doctor's attitude were helpful and sincere, you would be ready to listen to what he/she has to say.

You express yourself without difficulty; however, you are a little prudish when speaking of sexual matters. For 1½ years you have regularly gone to the family planning clinic and Dr Durant has prescribed Lyndiol as your oral contraceptive. You have been taking it regularly and are relatively satisfied.

Your problem today: you have come for a new oral contraceptive prescription with the underlying belief that taking the pill is incompatible with your tendency to obesity.

This is your first visit in six months. When you enter the consulting room, you realize that you will not see Dr Durant, but a "young doctor" instead ...

Role of the "doctor". You are a medical student interested in birth control. As part of your practical training, you are working in the family planning clinic at St Peter's Hospital. You are replacing Dr Durant who supervises each of your consultations. The information you require is in the clinical file attached.

Check-list for observers. What information did the consultant gather during the 15 minutes?

— Specifically: is it clear that the consultant understands the client's problem?

— Regarding the client's attitude to the problem: what kind of atmosphere has the consultant created? How did he act (verbal and non-verbal attitudes)?

— Is he concerned about preserving his relationship with the client?

— Is he considering together with the client solutions that are compatible with her way of life?

Role-playing for evaluation: individual interview

Situation 1. You are a general practitioner. A young woman comes to your consulting room. She seems nervous and tells you right away that she thinks she is pregnant. She will be 20 years old in a few months. The test proves to be positive. By now your client is seated in front of you. What will you say to her? What will be the outcome of the interview?

Situation 2. You are a general practitioner. A second client comes to your consulting room. She seems to be of Italian origin. She believes she is pregnant again. The test proves to be negative. She seems relieved, because she says "I don't know what I'd have done if I were pregnant again". How do you carry on with the interview? What will be its outcome?

Summary of discussions following circulation of the teaching package

The following criticisms were made:

— it is difficult to eliminate the lecture system;

— the methods proposed in the package require a great deal of time and a large number of qualified staff;

— it is dangerous to use teaching methods going beyond the technical level (for example, role-playing requires qualified organizers).

Reference should be made to similar work, such as the guide developed by Abbat for a WHO project and published in 1980 under the title *Teaching for better learning*, which demonstrates how:

— courses can be made relevant;

— the best possible teaching can be provided;

— performance may be evaulated; and

— evaluation tests may be developed.

The following positive factors were also given weight:

— recognition of the crucial nature of such matters as the initial contact between clients and health personnel, hitherto neglected;

— the fact that the teaching methods proposed are stimulating and should encourage development of a team spirit; and

— the possibility of making the programmes flexible and adjusting them to local conditions in terms of time available, personnel, resources, etc.

Conclusions

An evaluation questionnaire was distributed to all conference participants and many of them agreed to test the teaching method and suggest amendments to the editorial team which would continue to develop it.

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For further information, we refer the reader to the bibliographic bulletins on family health and family planning, published under the sponsorship of the WHO Regional Office for Europe and the International Children's Centre.

5

Summary of plenary meetings grouped by topic

Relations between health personnel and the community

Health personnel and political choices

Political choices play an important part in the introduction and establishment of family planning programmes.

Nations which are aware of their family planning needs organize themselves and act through associations, movements and pressure groups. In response to public pressure, political authorities sooner or later meet the needs of the community by providing it with the necessary administrative and other means and services.

In countries where a more or less considerable portion of the population feels no need for family planning, the political authorities who are aware of such a need are powerless and cannot deal with the opposition of the public without incurring major risks. Health professionals must assist the political authorities to put forward introductory family planning programmes in terms that are acceptable to the population.

Health personnel and culture

In the training of health personnel, matters related to fertility and its control can only be dealt with in the context of the life of the family as a whole, the culture of the country and the life of the community.

Health personnel must also take account of religious factors. In some countries, religion plays a considerable part in attitudes to sexual matters and the adoption or rejection of family planning.

Role of health personnel in relation to community organization, its needs and demands

The term "community" is too extensive since there are subcultures which follow their own laws: the world of the countryside or the town, adolescents, etc.

In the relations between health workers and the community:

— the ideal is for the community itself to diagnose its own behaviour, with personnel only acting as technicians for the formulation and solution of problems;

— a distortion of the relationship with the community can occur if it is used as a test bed, for example for the benefit of health personnel under training.

Needs expressed by the community of its own accord are not necessarily its priority needs. It is essential to prepare students for an epidemiological approach, enabling them to pick out at-risk groups and negotiate with the community a scale of priorities which would take account of all the needs observed.

Needs increase with the provision of services. If health personnel provide family planning services, members of the community will feel the need for them. Very frequently, there is a correlation between supply and demand.

Health personnel in relation to trends in the role of women and couples

The importance of the woman's role in family planning programmes has been stressed by all; unless women agree with it, no programme can succeed.

Family planning practices emancipate women; in many cultures this creates new problems of identification and relationships with men.

The changing roles of men and women make the problems of childbirth, the education of children and family life in general take on a new light, and they call for new solutions.

Preparation for and discussion of these new roles should begin in childhood. Some experiments in doing so have been conducted: sex education programmes at primary schools in Sweden, education for family life in kindergartens in the Federal Republic of Germany, etc.

Staff of family planning centres should be trained through continuous teamwork to receive both men and women, listen to them and help them find individual answers to their questions.

Organization of new types of training

A new programme

It is very difficult for a new training programme to be produced within an already existing framework. It presupposes sharp negotiation between different specialists, each of them defending the teaching time allocated to them.

If they are to be effective, psychosocial aspects should be incorporated in family planning programmes.

Health professionals should be trained in dialogue with those consulting them and in developing good relations with the latter that would assist in conveying what they have to say.

The training of health personnel should include matters relating to the management of services and programmes (e.g. transport, equipment and supplies, staffing, etc.).

A new distribution of tasks among personnel

With a view to reorganizing health services at the primary, secondary and tertiary level, the tasks of members of the various professions should be redistributed and teamwork introduced: Who does what? And with whom?

The physician may have a very thorough understanding of the different aspects of family planning without, however, being completely at home in such spheres as management, information, marital counselling, etc.

Given the present state of medical training and medical practice, some participants wondered whether it was possible to bring physicians into community work, asking whether it might not be preferable to call upon members of professions more in tune with the dynamics of communities. This opinion, based on the actual situation observed in many countries, shows how urgent it is to reorient the training of the medical professions so that a community perspective develops.

Paediatricians at the conference stressed the importance of their role in family planning. After all, it is they who initiate early contacts with the family, who supervise the growth and harmonious development of children, who advise mothers on ways of avoiding difficult pregnancies and major congenital diseases and who inform families of how to behave towards handicapped children. They should therefore have time devoted to family planning during their training.

The need for evaluation

Evaluation must be a continuous process and involve staff participation at all levels.

Evaluation must not be an activity designed and carried out by an outside agency; at every step it must involve the persons affected by the programmes.

To meet the concern of some participants over the time necessary for evaluation, it was stressed that although it is true that the development and introduction of protocols is bound to take a long time, their application is simple and does not take long.

A detailed analysis of tasks would make for rationalization of work and for better use of the time available.

Evaluation should relate solely to those factors that can promote decision-making.

Evaluation should go beyond the collection of statistical data and take into account qualitative factors such as the sociocultural or relational aspects of a programme.

It is essential for evaluation methods to be standardized so that comparable results between different services and regions in a given country may be obtained.

The aim of evaluation is not only to measure results of a programme at the global level but also to make it possible to improve services locally.

6

Recommendations and conclusions

Recommendations

General

The training of health personnel in family planning must take into consideration the family planning policies of countries, the needs expressed by the community, the roles and tasks of the personnel meeting those needs, and the conditions under which the personnel must work.

The education of health personnel should be related to local community needs and should be flexible.

Motivational activities

Motivational activities should be aimed at public opinion, pressure groups, decision-makers and training institutions, at national and local levels, in order to increase awareness of community needs regarding family health and the benefits of family planning, and also in order to guide the training of health personnel. This may be done through the mass media, specially programmed audiovisual material, seminars and workshops for the above groups, etc.

In addition, trainers (teachers) must establish personal contact with decision-makers in order to inform and establish dialogue with them.

Training of trainers

Interdisciplinary continuous training programmes (including refresher courses) should be organized for teachers, in order to update their knowledge and promote understanding and implementation of teamwork.

Training of trainers must be carried out at successive levels, providing both regional and local facilities for the purpose.

During their training teachers should learn about the community and its needs through practical field activities in and with the local community. They should learn how to work with the community and its leaders.

Teachers should be trained in the use of problem-oriented and problem-solving teaching methodology. Emphasis should also be given to teaching/learning methods enabling students to acquire practical skills and develop

attitudes of insight and understanding respectful of human rights. In order to achieve this, appropriate educational resources must be made available.

Teachers should be given an understanding of the problems and specific problems of adolescents and their sexuality, so that they may achieve better communication with them.

Organization of training

The curriculum content in family planning should be designed to enable the students to identify the needs of the community and to meet them, taking into account the sociocultural and economic aspects of family planning. For this purpose, stress should be laid especially on communication with the population, preparation for carrying out programmes and their evaluation.

Training in family planning should be integrated with various disciplines, but one of these should provide overall coordination of the training to ensure full coverage of the subject.

Sufficient time and logistic support should be available to expose the students to the community and enable them to identify its needs and participate in practical health care activities during their training.

Evaluation of training should be directed not only to checking the students' knowledge but, above all, to assessing their ability to perform tasks relevant to family planning.

The training of health personnel should stress the most effective and economical use of local resources.

International cooperation

Contacts between countries should be encouraged, facilitated and coordinated in order to provide an opportunity for them to exchange experience and possibly to cooperate in designing programmes and in testing teaching methods and materials.

Conclusions

The participants recognized that the teaching of family planning to physicians, nurses, midwives and other health personnel is at present far from satisfactory in most of the countries represented.

In basic training programmes, it usually consists of brief theoretical lessons on the clinical aspects of contraception, sterility or abortion. It was noted that there are weaknesses in practical training and no preparation for the relationship between health personnel and those who come to seek advice and care.

However, a number of experiments in multidisciplinary refresher training were reported, which provide excellent preparation for teamwork and clarification of the roles of the different members of the health team: reception, information, clinical examination, prescription, follow-up of clients, etc.

Conference participants recognized the importance of seeking to reconcile in any given community the felt needs, the expressed demands and the services offered.

With regard to training, it is thus important to ensure that health personnel not only receive clinical training but also learn to understand the environment in which they work, to meet the influential people in the community and, above all, to listen to women on whose full cooperation the success of any birth spacing policy is based.

Participants in the conference considered it desirable that training programmes should be developed in cooperation with primary health care teams and that they should focus on the demands of the clients.

It was considered essential to stress that evaluation should be undertaken together with basic health workers, and that it should be carried out by them in stages, with the help of suitable tools and procedures.

In setting out proposals for training in family planning for different categories of health personnel, a number of obstacles of various types arise: political problems with their effect on the existence and development of services in a country; problems of culture and religion, adults' and parents' values; individual problems of health professionals who are not accustomed to discussing sexuality, pleasure, the desire to have children, etc. There are other problems of an educational nature, due to the large number of students, the lack of facilities and the little time available because of the rigidity of traditional curricula.

To overcome these obstacles, the most important thing is to deal with the social and economic conditions in which communities live; to bring information to bear on public opinion; to educate teachers to identify community needs and to provide training in which the students will participate; and to teach students to develop not only knowledge and skills but also adequate attitudes so that they may serve the community.

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In the last 20 years, the most important aspect of family planning has been to present arguments on the benefits to be derived from birth spacing, on the structure of families and on the recognition of conjugal rights so that countries will provide their populations with services where there is some element of choice.

It is essential now to improve the organization of services at every level in order to meet needs. It is also important to give prominence to the training and role of health personnel so that they meet the expectations of communities and help fulfil the desire of members of the professions involved to go beyond pure treatment and tackle the problem at the personal level. The natural demands of women with regard to sexuality call for this new approach if lifestyles favourable to health are to be adopted, preventable conditions are to be reduced and acceptable and accessible levels of care are to be provided for all. This book tries to provide some of the information needed in such an effort.

Various aspects of family planning are reviewed; a number of different training units designed to develop and improve the teaching of different categories of health personnel were discussed in study groups. The relationship between health personnel and the community as well as the organization of new types of training are thus studied in detail. Conclusions and recommendations are included on activities involved in motivating and educating those involved in training, organizing teaching and international collaboration.